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ABSTRACT

The format for this curriculum guide, written for nurse practitioner faculty, consists of learning objectives, content outline, teaching methodology suggestions, references and recommended readings. Part 1 of the guide, Recognition of Early and Chronic Alcoholism, deals with features of alcoholism such as epidemiological data and theories, definitions, attitudes, and approaches to alcoholism; special populations and their needs; and biophysical and psychosocial consequences of alcoholism. Part 2, Diagnosis of Early and Chronic Alcoholism, addresses the assessment and diagnosis of alcoholism in a primary care setting, with emphasis on the assessment interview. Part 3, Management of Early and Chronic Alcoholism, deals with strategies used in the recovery process, e.g., mobilization, and formulation of a treatment plan. Specific treatment methods are covered, with the presentation of the phases of recovery, (initial detoxification followed by long-term rehabilitation, and aftercare). Family needs and problems during the recovery of the alcoholic family member are also addressed. A list of resources and audiovisual materials, the Short Michigan Alcoholism Screening Test, tables presenting major and minor Criteria for the Diagnosis of Alcoholism, a chart of Effects of Alcoholism on the Family, and the Seaman-Manello Scale (Form B) of Nurses' Attitudes Toward Alcohol and Alcoholism are appended. (LLL)

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Health Professions Education Curriculum Resources Series

Nursing

3

Alcohol Abuse Curriculum Guide for Nurse Practitioner Faculty

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Alcohol Abuse Curriculum Guide for Nurse Practitioner Faculty

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Foreword

Preventing alcohol and other drug abuse and assisting those already suffering from these problems are pressing national concerns, and the nursing profession is at the forefront of efforts to deal with them. Nurses working in a variety of settings have opportunities to offer education and treatment services. As a provider of primary care services, the nurse practitioner is in an excellent position to inform patients of health risks posed by the misuse of drugs and alcohol and to address these and related problems afflicting large numbers of Americans and their families.

Skillful performance of these tasks in prevention, diagnosis, and management of alcohol and other drug abuse does not happen automatically; it requires specific professional preparation. To promote alcohol and drug abuse education as an integral part of the training received by nurses and other health professionals, the National Institute on Alcohol Abuse and Alcoholism (NIAAA), with the cooperation of the National Institute on Drug Abuse (NIDA), initiated the Health Professions Education Project. A major activity of the Project, conducted by the National Clearinghouse for Alcohol Information (NCALI), is the development of curriculum guides for use by health professions educators. Although the present volume is intended primarily for faculty members who train nurse practitioners, the information it contains will be useful to a broad range of educators and practitioners.

Availability of curriculum guides is only one of the elements essential to ensuring that appropriate professional training in alcohol and other drug abuse occurs, but it is an important one. We hope that this guide and the others in the Curriculum Resources Series will make a meaningful contribution to that training process.

Robert G. Niven, M.D.
Director
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Alcohol Abuse and Alcoholism

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Introduction

Alcoholism is a pervasive and destructive yet highly treatable disease. It rarely is identified and often remains invisible in its early stages because the alcoholic person, his or her family, friends, and health care providers either fail to recognize problem drinking or deny or hide its existence. The denial system that so often accompanies alcoholism can be so powerful and convincing that those close to the alcoholic person often are caught up in the process. Unfortunately, by the time symptoms no longer can be ignored, irreparable damage may have occurred.

It is paradoxical that some health care providers help perpetuate this problem. Among individuals seeking primary care, an estimated 12 to 20 percent suffer from alcoholism. In addition, many more persons, especially family members, are affected by the consequences of this disease. Alcoholic persons are seen by health care providers in clinics, emergency rooms, and private offices, yet the disease is often undiagnosed. How is this possible?

Numerous factors contribute to the absence of recognition and early diagnosis. The alcoholic person is hesitant to admit a drinking problem because of the perceived social stigma attached to such an admission and the possibility that he or she may have to choose a life without alcohol, which is a very threatening prospect. Family members, friends, and health care providers may avoid the problem because they consider alcoholism a personal weakness and source of shame rather than a disease. They may feel uncomfortable if they identify closely with the alcoholic person because they themselves have similar drinking habits. Myths and misinformation regarding who, when, and how one becomes alcoholic further distort identification of the problem, sustain its invisibility, and discourage intervention.

An additional contributing factor in the delayed diagnosis and invisibility of the disease is the lack of adequate alcohol education in nursing and medical schools. Negative attitudes and practices can contribute to a low success rate with alcoholic clients. Health care providers who expect compliance and recovery often become frustrated with the relapsing nature of the illness and may unconsciously block out clues that point to the presence of alcoholism. Furthermore, symptomatology in the early stages is not clearly delineated. There is no typical clinical presentation; the diagnostic clues are often vague and subtle.

It becomes apparent that, when stigmatizing attitudes, myths, misinformation, denial, and inadequate education are juxtaposed with an illness as complex as alcoholism, the probability for early recognition and treatment is minimal. However, it has been demonstrated that, with adequate instruction and structured clinical learning experiences, attitudes can be changed and the health care provider can acquire the necessary skills to make the correct, early diagnosis and to intervene and manage effectively.

As primary care providers, nurse practitioners are in an excellent position to recognize, diagnose, and manage the alcoholic individual by calling on their nursing, physical assessment, and illness management skills. The practice sites of nurse practitioners are typically outpatient clinics and other primary care settings. Contact with alcoholic persons is frequent because the general population often gains entry into the health care system through these avenues. Nurse practitioners often spend more time with clients than other primary care providers and therefore may pick up clues earlier in the course of the disease. Skills in lifestyle assessment and management enable the nurse practitioner to focus on pertinent factors of daily living that indicate a problem with alcohol.

Nurse practitioners can expect varying levels of involvement with the diagnostic and management process, depending on their degree of independence. In a rural setting, the nurse practitioner may have responsibility for the entire workup and may follow the alcoholic person and family through the recovery process. In some settings, the nurse practitioner may be involved in the assessment and diagnosis but use other resources for management. Regardless of the circumstances of practice, the nurse practitioner must have a broad understanding of alcoholism as a disease and be able to diagnose and treat it effectively. This text is designed to aid the nurse practitioner in achieving these goals.

This guide covers three major areas of instruction: recognition, diagnosis, and management. It is targeted at nurse practitioner faculty who do not have expertise in alcohol education but who want to introduce alcohol instruction into their curricula. The core content is presented in outline form and is supported by recommended texts, background readings, and teaching methodologies. Students presumably already will have completed a generic program and possess history-taking, physical assessment, and clinical decisionmaking skills. The guide is designed so that the instructor can use this previously acquired knowledge as a basis for developing new skills specifically required for the recognition, diagnosis, and management of alcoholism.

Criteria for selecting and organizing the content are based on the belief that nurse practitioners function both independently and interdependently when engaging in illness and wellness care. In addition, the population with whom the nurse practitioner has contact is diverse in age, sex, and culture. Consequently, the guide emphasizes a generalist approach to clinical decisionmaking. Etiological and epidemiological factors are considered important. The various definitions of alcoholism will assist in the development of a clinically useful definition for early recognition. This guide deals with exploring personal attitudes toward alcoholism, in the belief that more positive attitudes will emerge. Groups at high risk for alcoholism also are examined in view of their special characteristics and needs.

Because alcoholism is a disease that affects physiological and psychosocial functioning in particular and subtle ways, there is a strong emphasis on its pathological consequences. By understanding the pathology, pertinent clues are less likely to be missed during the assessment process. This guide's organization of subjective data follows a health history format as this conforms to typical clinical practice in assessing all diseases. Clues particular to each health history section are considered; emphasis is placed on those interview techniques that facilitate rapport and information gathering; and the necessity of synthesizing subjective and objective data is stressed.

Mobilization is the key concept in the management of early and chronic alcoholism—physical, psychological, cultural, economic, social, and spiritual immobilization being frequent consequences of alcoholism. Part Three of this guide presents specific strategies for mobilization and intervention, available treatment methods, problems encountered in recovery, and family needs.

This text may be used to teach either one or two courses in schools or in continuing education programs. Regardless of how the material is taught, experimental learning, especially in the form of supervised clinical practice, must take place.

Learning Objectives

On completing this course, the nurse practitioner will be able to

- Analyze the epidemiology of alcoholism and apply these findings to clinical practice
- Analyze definitions of alcoholism and develop a new definition that will aid in early diagnosis
- Differentiate etiological theories of alcoholism
- Criticize past and present approaches to alcoholism and construct a personal approach congruent with current research
- Examine attitudinal barriers to recognizing alcoholism and analyze one's own attitude toward this illness
- Differentiate the special characteristics of population groups that predispose those groups to alcoholism
- Integrate current knowledge of the pathological effects of alcohol into the practice of assessment and diagnosis
- Gather and analyze the significant subjective and objective data that indicate the presence of alcoholism
- Synthesize subjective and objective data and formulate a diagnosis of alcoholism
- Discuss factors that contribute to immobilization in alcoholism
- Evaluate and carry out recovery strategies
- Discuss the variables inherent in matching client to treatment method
- Identify the factors in the client-nurse practitioner relationship that influence recovery outcomes
- Assess and support the ongoing health needs of the alcoholic person and his or her family
- Identify barriers to treatment and discuss how they can be eliminated
- Discuss and evaluate specific treatment methods

- Formulate a treatment plan appropriate for an alcoholic individual
- Evaluate alcoholism treatment resources in the community and design a plan to enhance these services
- Assess and support family health and the needs of individual family members during recovery

Texts

The author uses the following texts:

Estes, N.; DiJulio-Smith, K.; and Heinemann, M. E. Nursing Diagnosis of the Alcoholic Person. St. Louis: Mosby, 1980.

Johnson, V. I'll Quit Tomorrow. New York: Harper & Row, 1973.

***

Please note the recommended references and background readings for instructors found at the end of each teaching unit. These selections are also useful as assigned readings for student enrichment purposes.

Part One: Recognition of Early and Chronic Alcoholism

Features of Alcoholism

Rarely are health care providers aware of the extent of alcoholism, the complexity of its etiology, the difficulty of defining this entity, and the variety of society's responses to it. This unit seeks to increase nurse practitioner awareness of these issues by providing basic knowledge applicable to early recognition of the disease. Health care providers' attitudes toward alcoholism are examined and personal attitude exploration is emphasized so nurse practitioners can recognize and overcome their own negative attitudes.

Learning Objectives

On completing this unit, the nurse practitioner will be able to

- Consider findings from epidemiological studies and apply them to clinical practice
- Examine the course of the disease and expected consequences
- Discuss the various definitions of alcoholism and their clinical applicability
- Examine the etiological theories of alcoholism based on current research
- Discuss the positive and negative aspects of the various approaches to alcoholism
- Discuss what influences health care providers' attitudes toward alcoholism
- Examine personal attitudes toward alcoholism

Content Outline

I. Epidemiological Data on Alcoholism

  A. A major health problem in the United States affecting 9.3 to 10 million people (NIAAA 1978b)

    1. Adults: 1 in 10 who drink suffer from alcoholism

      a. 5 to 10 percent of males

      b. 1 to 5 percent of females

    c. 3:1 to 4:1 male-female ratio

2. Youth: 19 percent between 14 and 17 years old are problem drinkers

3. Elderly: 10 percent over 60 years old suffer from alcoholism

4. Others: 33 to 44 million additional lives are affected by an alcoholic person

B. High prevalence of alcoholic clients in health care facilities (NIAAA 1978b)

1. Private offices/clinics: 12 to 20 percent

2. Emergency rooms: 30 to 35 percent

3. Medical-surgical wards: 30 percent

4. Mental health centers: 30 percent with primary diagnosis of alcoholism

C. Course of disease: typical pattern (Schuckit 1979)

1. Onset at 23 to 33 years of age

2. Intermittent social drinking for 10 to 12 years before onset of disease

3. Insidious, progressive pattern over next 5 to 20 years

4. Start of treatment about 10 years into course of disease (40 years old)

5. Great variability in disease course, marked by

    a. Periods of abstinence alternating with active drinking

    b. Problems with health, family, job, law

6. Outcome variables

    a. Spontaneous remission or response to nonspecific intervention in one-third of cases

    b. Shortening of life span by 10 to 12 years

    c. Usual causes of death

        (1) heart disease

        (2) cancer

        (3) accidents

        (4) suicide: 22 to 23 times higher rate than general population

D. Risk factors (Estes and Heinemann 1977)

1. Vulnerability cutting across age, sex, culture
    a. Average alcoholic person: white male with job and family still intact
    b. Stereotypic skid row residents: less than 5 percent of U.S. alcoholic population
2. Specific risk factors identified from research include
    a. History of alcoholism in family: parents, siblings, grandparents, aunts, uncles
    b. History of teetotalism in family in presence of strong moral overtones
    c. History of alcoholism or teetotalism in spouse or family of spouse
    d. History of a broken home or one with much parental discord; absent or rejecting but not punitive father
    e. Position as last child of large family or in last half of sibship in large family
    f. Member of cultural group with higher incidence of alcoholism
    g. Family history with more than one generation of female relatives manifesting recurrent depression
    h. Heavy smoking

II. Definitions of Alcoholism (Estes et al. 1980; Schuckit 1979)

A. Definition needed for clinical practice to provide
    1. Basis for assessment
    2. Facilitation of diagnosis
    3. Organization of management strategies

B. Requirements of definition (most are subjective, vague, restrictive) include
    1. Objectivity and precision
    2. Broadbased in nature

C. Current definitions
    1. Quantity-frequency definition
        a. Is based on quantity consumed, frequency of use, patterns of drinking
        b. Uses data gathered from alcoholic persons that are frequently distorted by

    (1) person's poor memory when intoxicated

    (2) usual presence of denial

  c. Needs individual adjustment because amount required to cause problems will vary greatly with age, sex, weight, race, and concomitant drug use

2. Psychological dependence definition

  a. Is based on degree of psychological discomfort experienced when alcohol is unavailable

  b. Depends on highly subjective patient reports, influenced by denial

3. Physiological dependence definition

  a. Is based on presence of certain physiological manifestations called withdrawal syndrome, which follows sudden decrease in or absence of alcohol after prolonged, heavy drinking

  b. Indicates alcoholism but is not sole criterion since

    (1) many persons never drink enough to elicit withdrawal symptoms

    (2) these same persons experience the destructive effects of alcohol-related problems

4. Presence of alcohol-related, life problems definition (Schuckit 1978)

  a. Is based on presence of serious life problems engerdered by alcohol

  b. Looks at highly vulnerable life areas including

    (1) health: acute and chronic problems

    (2) family: separation, divorce

    (3) job: demotion, loss of job

    (4) law: DWIs, arrests

  c. Defines persons as having alcoholism when, despite alcohol-engendered problems, they continue to drink

  d. Will often elicit history of heavy drinking and presence of physical and psychological dependence

  e. Defines persons as probable alcoholics when they demonstrate some minor problems in these areas but destructive sequel is not yet evident

  f. Provides highly applicable approach for general screening and problem assessment in clinical practice

5. "Criteria for Diagnosis of Alcoholism" definition (Estes and Heinemann 1977) (see text of "Criteria" in Appendix D)

    a. Classifies significant alcohol-related symptomatology

    b. Weighs criteria according to diagnostic significance, formulating diagnostic levels 1 to 3

    c. Provides a valuable tool for formulating a definition and synthesizing data for diagnosis

III. Etiological Theories of Alcoholism (Estes and Heinemann 1977; Estes et al. 1980; Goodwin 1974; Oxford 1976)

A. Multifocal cause

1. Theory is predicated on interaction of cultural, social, psychological, and genetic factors

2. Development of disease may or may not occur for persons with risk factors

3. Continued research is needed to further delineate the etiology of alcoholism

B. Current theories

1. Genetic theories

    a. Evidence of genetic predisposition

        (1) not known if specific gene exists or a cluster of inheritable factors are transmitted

        (2) results of adoption studies by Goodwin (1974) demonstrate

            (a) clearest evidence to date

            (b) in adoptees separated from alcoholic, biological parents soon after birth and raised by nonalcoholic foster parents

                (i) children of alcoholic parents had nearly four times higher rate of alcoholism than control group adoptees

                (ii) greater severity of alcoholism in natural parents predisposed higher incidence in offspring

    b. Interplay of other factors

        (1) offspring of alcoholic parents may not develop alcoholism; offspring of nonalcoholic parents may develop alcoholism

        (2) further research is needed

2. Psychological theories

- a. Personality theory
  - (1) research cannot document causal traits
  - (2) no single characteristic or cluster of traits is common to all alcoholic persons
  - (3) traits found in some alcoholic persons include
    - (a) low frustration tolerance
    - (b) poor impulse control
    - (c) dependency conflict
    - (d) weak ego strength
    - (e) exaggerated sensitivities
    - (f) emotional immaturity
    - (g) sexual immaturity; sexual conflict
    - (h) inability to postpone gratification
    - (i) sense of powerlessness
  - (4) fifty percent of men with antisocial personalities develop alcoholism
  - (5) alcoholic women have a higher incidence of depression than nonalcoholic women and alcoholic men
- b. Transactional theory
  - (1) alcoholism creates distinct interactional patterns in alcoholic families
  - (2) resulting interaction controls communication patterns
  - (3) family patterns enable responsibility avoidance
  - (4) the "game of alcoholism" ensues
- c. Learning theory
  - (1) drinking behavior is somehow rewarded or reinforced so that
    - (a) pleasure, comfort increase with use
    - (b) alcohol removes discomfort
  - (2) continued drinking leads to tolerance and possible alcoholism

3. Social theory

   a. Individuals experiencing social deprivation, social stress (anomie, poverty, powerlessness) may consume excess alcohol as an antidote

   b. Advertising and media techniques enhance consumption, which increases likelihood of developing alcoholism

4. Cultural theory

   a. Certain cultural groups have higher rates of alcoholism

   b. Cultural groups with a lower incidence of alcoholism tend to have proscriptions against alcohol abuse and tend to accept drinking in the following ways:

      (1) use with meals

      (2) attach no particular significance to drinking

      (3) give no positive reinforcement for increased consumption

      (4) discourage intoxication

      (5) expose children early, so use is not perceived as an adult behavior

   c. All cultural groups are vulnerable to alcohol problems so that

      (1) practitioners cannot rule out an alcohol problem on the basis of cultural affinity

      (2) heterogeneity complicates research

IV. Approaches to Alcoholism (Estes et al. 1980)

A. Awareness of different approaches

   1. Nurse practitioner needs to know how alcoholism is viewed by client and family

   2. Management strategies need to be based on belief system and lifestyle of client and family

B. Moral approach

   1. History and characteristics

      a. Begun in early 1800s by Temperance Society

      b. Initially dedicated to temperate drinking

      c. Later evolved into attempt to establish abstinence

d. Perceived alcohol as evil and immoral

e. Perceived persons with alcoholism as also evil and immoral, being

(1) considered hopeless, disgraceful, and willfully destructive

(2) blamed for their affliction

f. Influenced alcoholism to become a moral issue with stigmatization of the alcoholic person and family

2. Consequences

a. Caused denial and hiding of disease, with

(1) perpetuation of feelings of low self-worth and guilt

(2) failure to seek help early in the course of alcoholism

(3) isolation and stigma with increased likelihood of using alcohol for antidote

b. Caused increase in morbidity, mortality

c. Caused moral attitudes to be deeply ingrained in society, resulting in

(1) myths and misinformation that still exist

(2) negative attitudes that are difficult to mitigate

(3) health care providers who often are unaware of their own moralistic views

C. Disease approach (Clark 1980)

1. Characteristics

a. Began in early 1960s with first description of symptom progression

b. Defines alcoholism etiology, symptomatology, particular course, and amenability to treatment as consistent with a disease model

c. Accepts an individual's volitional control as not possible

d. Places responsibility for cure with society and health providers

e. Sees appropriate setting for treatment as health care centers with professional staffs

f. Specifies complete abstinence as only means of recovery

2. Consequences

a. Stigmatization decreased

b. Casefinding and early treatment became easier

c. Treatment facilities and research increased

2. Problems

a. Views alcoholic person as passive victim not responsible for illness or recovery

b. Does not consider alcoholism as interplay of multiple factors

c. Deemphasizes sociocultural factors

D. Behavioral approach (Estes and Heinemann 1977; Estes et al. 1980)

1. Characteristics

a. Assumes alcoholism is learned behavior

b. Views society as constantly reinforcing drinking, so that

(1) early in life, parental alcohol use serves as a model

(2) peer group pressure and social acceptance further reinforce drinking

(3) alcohol is used to manage life stresses

c. Perceives chronic consumption as increasing the risk of alcoholism development

d. Indicates reinforcement occurs with the addiction experience, so that

(1) cessation of drinking causes withdrawal symptoms

(2) symptoms are best relieved with alcohol

e. Uses treatment based on the learning theory model, in which

(1) clients learn to change their response to alcohol

(2) clients learn new strategies to cope with stress

2. Problems

a. Inconclusive research that suggests that alcoholism is learned behavior

b. Lack of consensus regarding appropriate treatment goals

V. Attitudes (NIAAA 1978b; Oxford 1976)

A. Alcohol-related attitudes

1. Societal influence

a. Society's current encouragement of social drinking, acceptance of excessive drinking, and stigmatization of alcoholism

b. Origins of current attitudes

(1) early American drinking practices associated heavy drinking with masculinity

(2) religious influences are important factors, reflecting

(a) failure of Temperance Society and Prohibition efforts

(b) resulting attitudes toward alcoholism that are moralistic, confused, and ambivalent

2. Family influences

a. Parental attitudes and practices

b. Attitudes and practices brought from family of origin to own marriage

c. Partner's influence in causing modification or enhancement of attitudes

3. Group attitudes: adoption of drinking norms of an individual's associative groups (religious, ethnic, family, cultural)

4. Psychological factors

a. Use of distancing

(1) fear of own vulnerability leads individual to view alcoholic person as different, to be avoided or condemned

(2) judgmental, moralistic, and punitive attitudes develop

b. Factors contributing to poor physical and psychological self-image of alcoholics

(1) others feel threatened by the alcoholic individual

(2) others see the alcoholic person as a frightful, disabled individual

(3) individuals project their fears onto others to feel more personally secure

c. Interaction of familial, psychological factors

(1) children exposed to alcoholism in family may develop strong reactions, such as negative and hostile attitudes, abstinence

        (2) adults project childhood fears and feelings on the alcoholic person

    d. Effect of media, advertising

        (1) the media reinforce stereotypic ideas of alcoholic persons

        (2) the media encourage alcohol use through persuasive alcohol symbols, such as status, adventure, physical attractiveness, and fun

5. Peer influences

    a. Influential effect of friends, coworkers, companions in determining attitudes and behaviors toward alcohol

    b. Tendency to respond to peer pressure

    c. Tendency to associate with those who have similar attitudes and practices

B. Attitudes among health care providers

1. Prevailing attitudes

    a. Immersion in the same alcohol-related social attitudes that influence entire society

    b. Perpetuation of ignorance through lack of alcohol information and poor instructor role models

    c. Continuance of negative attitudes

2. Factors perpetuating negative attitudes

    a. Lack of preparatory alcohol education in professional schools

    b. Exposure to experienced professionals with negative attitudes

    c. Failure of misdirected approaches

        (1) frustration arises from lack of success, with confusion and anger ensuing

        (2) the provider faces the dilemma of not fulfilling the professional role

        (3) defense mechanisms emerge, including

            (a) rationalization

            (b) denial

            (c) avoidance

        (4) myths and misinformation are perpetuated

3. Factors promoting positive attitudes

   a. Experience, education

      (1) exposure to the alcoholic person decreases myths and stereotypic ideas and allows identification with the alcoholic as a person

      (2) education provides the knowledge base and skills for dealing with chronic relapsing illness

   b. Formulation of realistic goals

      (1) the health care provider needs to consider short-term goals for improvement

      (2) the focus needs to be on success of sobriety, not failure in relapse

      (3) success needs to be seen as small changes in behavior

   c. Exploration of personal attitudes

      (1) attitudes about drinking, alcohol, alcoholism, and alcoholic persons need to be examined, including

         (a) exploring influences of childhood, adolescence, marriage, education, society, media, and professional practice

         (b) working through conflicts and frustrations

         (c) identifying factors that support negative attitudes

      (2) ultimately, objectivity should develop

Teaching Methodologies

The first four subjects in the content outline (epidemiology, definitions, etiological theories, approaches) are most effectively presented in the lecture/discussion format. Readings from Nursing Diagnosis of the Alcoholic Person (Estes et al. 1980) are particularly valuable for the students. The "Criteria for the Diagnosis of Alcoholism" (Appendix D) is a tool that should be introduced in this chapter. It will be used more extensively in Part Two, so each student should have a copy.

The fifth subject area (attitudes) requires a seminar format with prior readings (NIAAA 1978a). Small groups of three to four students allow enough time for each student to explore personal attitudes toward alcoholism. This type of introspection may reveal painful and conflicting feelings, and the seminar instructor should be prepared to help the student work through these in a supportive, direct manner. Myths and misconceptions should also be examined. This may be done as an introduction to personal attitude exploration or as a pretest with class discussion followup.

References and Recommended Background Readings

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Special Populations

This unit addresses the special characteristics and needs of women, adolescents, the elderly, blacks, Hispanics, Native Americans, and Asians. In these special population groups, alcohol problems often have been overlooked because of differing lifestyles and minority status. In addition, most research to date has examined the white, middle-class male, and few of the findings adequately or correctly apply to other populations. Consequently, alcohol problems among members of special population groups often remain undetected and untreated. These persons continue to drink until their lives and health are seriously damaged.

Individuals from these minority groups frequent primary care clinics and have ongoing contact with health care providers. It is important to increase awareness among practitioners that alcoholism exists to a significant degree in their clients and to increase knowledge of the contributory cultural factors unique to each group. Proper understanding of culture-specific influences will enhance the practitioner's role in early diagnosis, intervention, and treatment planning.

Learning Objectives

On completing this unit, the nurse practitioner will be able to

- Differentiate special characteristics and needs of various population groups
- Consider how characteristic group responses to alcohol and alcoholism affect the identification, assessment, and diagnosis of individuals with alcoholism
- Use this knowledge of special group characteristics to formulate an appropriate clinical approach to the individual with alcoholism

Content Outline

I. Women (Bourne and Light 1979; Estes et al. 1980)

  A. Prevalence

    1. Adult women with alcoholism

      a. Women have developed drinking patterns similar to men

      b. Adult women with alcoholism are estimated at 1.5 to 2.25 million or 15 to 22.5 percent of the total alcoholic population in the United States

    2. Possible reasons for increased incidence

      a. Societal proscriptions on women have loosened

      b. Homemaker role has low visibility and high flexibility, which supports covert drinking

      c. Recent increase in nontraditional roles has

        (1) placed women in high stress situations

        (2) encouraged the formulation of use patterns similar to males

d. Increased awareness has led to increased case finding

e. Disease concept has enhanced acceptance of alcohol problems

B. Special characteristics of alcoholic women

1. Causative factors (research data are not definitive, but the following factors have been identified as possible links to the development of alcoholism)

   a. Precipitating factors (often stressful events), including

      (1) social factors: death of spouse or parent, divorce, and children leaving home

      (2) physical factors: hysterectomy, menopause, and infertility

      (3) psychological factors: poor self-concept, sex role conflict, and middle-age crisis

   b. Biophysiological factors, including

      (1) greater likelihood of having parents (especially a father) who are alcoholic: prevalence rates are as high as 50 percent

      (2) high incidence of family history of affective disorders in female relatives

      (3) presence of physiological factors affecting women

         (a) a relationship exists between sex hormones and alcohol metabolism in which

            (i) alcohol use may be related to changes in sex hormone balance, such as menstrual cycle changes, the postpartum period, and menopause

            (ii) increased alcohol use may be linked with low estrogen levels

         (b) hormonal changes and mood fluctuations may foster alcohol use as self-medication

2. Differences between women and men

   a. Metabolic responses to alcohol: in base-adjusted experiments, responses differ as follows:

      (1) women consistently obtain higher blood alcohol levels (BAL) than men

      (2) women absorb alcohol faster and reach peak BAL sooner

      (3) white women show greater variability in peak BAL from test to test while men remain consistent

b. Course of disease

(1) women become alcoholic at a later age than men: 35 to 64 years

(2) women experience a telescopic effect, with more virulent consequences in a shorter period of time

(3) cirrhosis incidence is increased

(4) average death age for alcoholic women is earlier than for men: 48.6 vs. 56.3 years

C. Psychosocial factors characterizing alcoholic women

1. Early life deprivation: more likely than in general population

2. Marriage and divorce: marry to same extent as general population but have higher divorce rates

3. Alcoholic families: more likely than men to have alcoholic spouse or father

4. Depression: more likely than men to experience depression, with a suicide rate 23 times higher than the general population

5. Family relationships

a. Ninety percent of alcoholic women are abandoned by their spouses

b. If family stays intact, members tend to protect the woman and discourage help

6. Multidrug use among alcoholic women

a. Sixty percent use other drugs, especially psychotropic drugs

b. Seventy-five percent have acquired these drugs from physicians because

(1) women are more likely than men to engage in health-seeking behavior

(2) physicians are socialized to believe females have more psychological problems that need drug treatment than do men

c. Concomitant use of drugs and alcohol puts women at high risk for overdose

7. Lesbian women

a. This population experiences higher rates of alcoholism than their heterosexual counterparts

b. Identified causative factors include isolation, fear, and alienation

c. Bars (the milieu that allows acceptance and camaraderie for lesbian women) enhance risk of alcoholism

D. Assessment needs

1. Maintenance of a high index of suspicion of alcohol problems, multidrug use, and depression
2. Awareness of own attitude about women and alcoholism
3. Development of mutual, participatory relationship
    - a. Women will often have poor self-concept and be unassertive and submissive
    - b. Women will need help in assuming responsibility for recovery, to
        - (1) increase their awareness of and help focus on personal needs
        - (2) help avoid drinking traps; for example, self-blame, isolation
4. Evaluation of depression (Schuckit 1979)
    - a. Suicide potential needs to be determined
    - b. Health care provider needs to distinguish between primary and secondary depression etiology by
        - (1) screening for preexisting, primary affective disorder (extended periods of depression or mania before onset of first alcoholic life problem or during extended abstinence)
        - (2) taking into account the difficulty of determining a preexisting disorder until client has been alcohol-free for 6 to 12 months. when psychological testing can be done

II. Adolescents (Estes and Heinemann 1977; Estes et al. 1980)

A. Prevalence

1. Extent of drinking among high school students
    - a. From 80 to 90 percent of teenagers report taking a drink (79 percent males, 70 percent females)
    - b. Among high school seniors, 50 percent report using alcohol three times a month, and 6 percent use it daily
2. Drinking pattern differences between males and females
    - a. Males drink more frequently and in greater amounts
    - b. The gap between frequency and amount of drinking according to sex is closing
3. Characteristics of adolescent heavy drinkers

    - a. Use of other drugs, especially marijuana, is frequent
    - b. Drinking starts at an earlier age than for other teenage drinkers
    - c. Weekend binge drinking with peers is common
    - d. Problem behavior symptomatology is often exhibited

B. Significant factors surrounding use

  1. Role modeling of adult behavior

  2. Influences of parents, peers, and religion, with peer use demonstrated to be strongest influence in certain contexts

  3. Reasons for use reported by teenagers
    - a. To enhance a good time: 56 percent
    - b. To enhance acceptance by group: 19 percent
    - c. To cope with problems: 25 percent

C. Special characteristics

  1. Biophysiological considerations
    - a. Adolescents generally demonstrate a lowered tolerance for alcohol, possibly due to increased nutritional needs for growth or to lower body weight/muscle mass
    - b. Blackouts and "morning after" shakes have been reported
    - c. Some adolescents have demonstrated withdrawal symptomatology indicating physiological dependence

  2. Psychosocial considerations
    - a. Adolescents are involved in developmental tasks of forming identity and learning to cope with life problems
      - (1) adolescents who lack emotional capacity and a support system to accomplish these tasks may become overwhelmed and turn to alcohol for escape
      - (2) alcohol misuse further delays the adolescent's emotional and social development, so that a vicious cycle ensues
      - (3) alcohol misuse can become a general adaptation to life
    - b. Adolescents are naive drinkers who
      - (1) lack experience with side effects

        (2) are prone to take more risks than adults

        (3) are in danger when alcohol and risk taking are combined with new skills; for example, driving automobiles

D. Assessment considerations

  1. Assessment parameters

    a. Few adolescents meet adult diagnostic criteria or life problem definition for alcoholism because they

        (1) have not been drinking long enough to demonstrate physiological symptomatology

        (2) have yet to establish and stabilize life areas such as family and job

    b. Although only a limited number of adolescents are clinically alcoholic by adult standards, many adolescents drink heavily and can be considered to have acute or chronic alcohol problems

        (1) an appreciable percentage of adolescents demonstrate significant alcohol-related problems, including driving while intoxicated, fights, loss of a friend or serious damage to a friendship, accidents involving injury, job-related problems, and trouble with authorities

        (2) behavior problems in school and with family may possibly be indicative of a chronic alcohol problem

  2. Approach to the adolescent

    a. Relationships need to be established on the basis of respect and trust, with emphasis on individuality

    b. Safe, nonjudgmental atmosphere needs to be provided

    c. Self-assessment, problem exploration, and alternative solutions to alcohol use should be encouraged

III. Elderly (Estes et al. 1980; Mishara and Kantenbaum 1980)

A. Prevalence

  1. Estimated prevalence of alcoholism among elderly persons over 65 years old: 10 percent

  2. Slightly lower percentage of elderly women than elderly men are alcoholic (greater longevity of women affects prevalence in later years)

  3. Characteristics of typical elderly alcoholic individual

    a. Is white and lives alone

        - b. Is likely to drink daily, alone at home
        - c. Consumes less alcohol than younger alcoholic persons
        - d. Rarely becomes intoxicated

- B. Significant factors surrounding use
    - 1. Stresses of advancing age
        - a. Has experienced loss of health, social and family support, productive ability, economic independence
        - b. Uses alcohol to escape loneliness, depression, loss, chronic illness
    - 2. Low visibility of problems reinforced by the elderly's drinking patterns
    - 3. Biophysiological considerations
        - a. Tolerance to alcohol is less than when younger because of
            - (1) differences in metabolism
            - (2) decrease in muscle mass and water volume
        - b. Quantity-frequency indicators are unreliable in this group: the effect of alcohol is the best indicator
    - 4. Multidrug use
        - a. The elderly consume larger quantities of drugs than younger people
        - b. An increased risk of alcohol-drug interactions exists because
            - (1) alcohol may enhance medication effect
            - (2) alcohol may destroy therapeutic value of medication
- C. Assessment considerations
    - 1. Diagnostic difficulties
        - a. Invisibility is maintained by
            - (1) the elderly person's lifestyle, social status
            - (2) the family's denial, protection, and enabling behavior
            - (3) the health provider's low index of suspicion and focus on aging, chronic disease etiologies
        - b. Symptomatology of alcoholism among the elderly is subtle, so that

        - (1) alcoholism should be suspected when an individual presents indications of trauma, malnutrition, tremulousness, unexpected reactions to drugs, withdrawal symptoms, or social isolation
        - (2) any such symptoms require thorough assessment, including a home visit

2. Determination of situation surrounding the onset of illness
    - a. Characteristics of the "Early Onset" group
        - (1) alcoholic drinking began at a young age
        - (2) drinking continued until old age
        - (3) reasons for drinking, patterns of use, and consumption are similar to those of younger alcoholic persons
        - (4) chronicity suggests poor prognosis, coincident with
            - (a) chronic physical debilitation
            - (b) absence of psychological and social supports
        - (5) close surveillance, adequate medical care, and supportive strategies are required
    - b. Characteristics of the "Late Onset" group
        - (1) drinking was moderate and without problems during early life
        - (2) a more stable and productive life has been led than in the "Early Onset" group
        - (3) alcohol is now used
            - (a) to combat such stresses of aging as loss of family, supports, jobs, income, self-esteem; feelings of loneliness, bereavement, depression
            - (b) to ameliorate these feelings of loss, with dependence being generated by alcohol use
        - (4) outcome is hopeful and positive, coincident with
            - (a) mobilization of social contacts and supports
            - (b) reinforcement of personal strengths and attributes
            - (c) increase in self-esteem, usually resulting in diminished alcohol use

IV. Blacks (Bourne and Light 1979; Estes et al. 1980)

A. Prevalence

1. Consideration of alcoholism as serious health and social problem in black community
2. Differences between black and white males
    a. Larger number of blacks abstain (38 percent) than whites (31 percent)
    b. Fewer blacks are heavy drinkers (19 percent) than whites (22 percent)
    c. Black alcoholic persons tend to be younger with onset of alcoholism earlier
3. Differences between black and white females
    a. Larger number of blacks abstain (51 percent) than whites (39 percent)
    b. More blacks are heavier drinkers (11 percent) than whites (6 percents)
4. Higher incidence of alcohol-related assaults, homicides, and accidents among blacks
5. Typical drinking patterns of blacks
    a. Weekends begin Friday after pay check and last until Sunday
    b. Small drinks are "sipped" throughout the day
    c. Alcohol is an essential ingredient in social intercourse
    d. Drinking usually occurs in taverns with peers
    e. Individuals tend to drink excessively or not at all, with abstinence usually chosen for religious reasons
    f. Alcohol tends to be used as a prestige symbol

B. Significant factors surrounding use

1. High-risk environment: black men who have experienced poverty, truancy, failure in early school years, and family instability grow up at increased risk
2. Social stressors: potent causative factors reflect sense of powerlessness, alienation, stigmatization
3. Peer influence: black peer groups may support drinking and condone heavy drinking
4. Accessibility: heavy consumption is linked to high accessibility of bars and liquor stores in the black community
5. Risk factors for black women

        - a. Coming from nonrural background
        - b. Not attending church regularly
        - c. Being apt to drink in public places
        - d. Being permissive about men drinking
        - e. Drinking to escape
        - f. Having heavy, problematic drinker (who is significant other) at home

- C. Biophysiological considerations
    - 1. Cirrhosis morbidity: 44 percent higher among blacks
    - 2. Increased likelihood of experiencing withdrawal complications
        - a. Complications are secondary to general substandard living
        - b. Exacerbation of preexisting hypertension causes cardiovascular strain and organ damage
    - 3. Complications in sickle cell anemia from alcohol use
        - a. Anemia secondary to alcohol toxicity causes further compromise to the individual
        - b. Withdrawal precipitates crisis
- D. Assessment considerations
    - 1. Increased severity of course of alcoholism in blacks
        - a. Nutritional status is generally poorer, causing greater susceptibility to the toxic effects of alcohol
        - b. Medical treatment may be delayed until the client is unable to accomplish activities of daily living; physical degeneration from alcohol may therefore be more severe
    - 2. Differing alcohol-related language in blacks
        - a. Unfamiliar terms may obscure assessment
        - b. Terminology needs to be clarified

V. Hispanics (Estes et al. 1980)

- A. Prevalence (data are insufficient to document pervasiveness of illness; rates are based on physical and social consequences of alcohol use)

1. Higher incidence of alcohol-related deaths among Hispanic youth than white youth

2. Higher incidence of alcohol-related deaths due to liver disease among Mexican Americans

3. Greater incidence of alcohol use prior to an offense among Hispanic youth (one-half) than Anglo youth (one-third) or black youth (one-fifth)

B. Significant factors surrounding use

1. Slow assimilation into Anglo society

a. Hispanics tend to turn inward and cling to own language, customs, and traditions

b. Immigrants may have failed to acquire skills and language needed for upward mobility

c. Many remain concentrated in lower socioeconomic strata

d. Social stressors of powerlessness and alienation encourage use of alcohol as antidote

2. Other potentially contributory cultural factors

a. Machismo factor may have positive and negative effects because it

(1) fosters concept that manliness is related to ability to hold strong liquor, which engenders tolerance

(2) does not glorify excessive drinking

(3) makes the admission of an alcoholism problem difficult, because seeking help is contrary to acceptable machismo behavior

(4) means the loss of face as an alcoholic can be intolerable to the individual

b. Family reluctance to seek help may deter treatment because

(1) when a male member has alcoholism, the family may not seek help if this is contrary to his wishes

(2) the family is seen as a source of pride, and the stigma of alcoholism would reflect on everyone within the family

VI. Native Americans (Estes et al. 1980)

A. Prevalence

1. Important as number one health problem among Native Americans

2. Alcohol-related death rate: 4.3 to 5.5 times higher for Native Americans than for all U.S. racial groups

3. Prevalence by age: highest in 25- to 44-year age group

4. Prevalence by sex: men outnumber women 3:1

5. Drinking patterns

    a. Drinking occurs in groups with friends and extended family

    b. Cultural norms of generosity promote free sharing of alcoholic beverages

    c. Drinking tends to continue steadily until all alcohol has been consumed

B. Significant factors surrounding use

1. Historical factors considered causative

    a. Native Indian tribes had own cultural proscription for use of wines and beers

    b. White man introduced hard liquor for which there was no proscription

    c. Booming liquor trade was linked with undermining of Indian cultures

    d. Alcohol abuse became dramatic problem

2. Reinforcement of drinking by subsequent social stressors

    a. Native Americans feel sense of powerlessness, alienation

    b. Native Americans face a lack of opportunities, inferior education, prejudice

3. Positive influences against drinking: the Native American Church recommends abstinence

C. Assessment considerations

1. Cultural values: diagnosis will be influenced by the Native American's value system, particularly

    a. Orientation to the present

    b. Nonurgent sense of time

    c. Control of outward reaction to physical discomfort

2. Indicators of alcoholism: the common drinking pattern of rapid, excessive, frequent drinking is not the sole indicator of alcoholism

    a. Further evaluation is needed in light of the cultural context

    b. Effects of drinking will be more informative than drinking pattern

VII. Asian Americans (Estes et al. 1980)

A. Prevalence

1. Historical rates: alcoholism rates have been low for Asian Americans due to physical and cultural factors

2. Current trends: increased exposure to western society is causing changes in traditional, moderate drinking patterns

B. Significant factors surrounding use

1. Biologic sensitivity

a. Symptoms include facial and upper body flushing, increased heart rate, decreased blood pressure, nausea, dizziness, pounding in head, and tingling sensations

b. Symptoms are dose related

c. Suggested causes include

(1) higher concentrations of acetaldehyde in Asians

(2) variation of autonomic response

(3) accelerated metabolism secondary to anatomic variation (larger livers, longer intestines)

2. Cultural considerations

a. Asian Americans tend to have negative attitudes toward intoxication

b. A stigma is attached to alcoholism

C. Assessment considerations

1. Personal approach: Asian Americans value a personal approach rather than professional intervention, and are likely to accept help from family and friends before accepting help from outsiders

2. Cultural values: Asian Americans value smooth social relationships and may therefore

a. Be polite, courteous, and agreeable to outsiders regardless of their real feelings

b. Fail to express their true feelings with subsequent poor compliance, which may hinder assessment and recovery

c. Achieve an enhanced interpersonal relationship if the caregiver can accept these values and work with the individual in his or her own milieu

Teaching Methodologies

Lecture with discussions is suggested. Prior readings from the list of recommended background readings will enhance the discussion. The students might be asked to investigate a high-risk group they encounter and share their findings with the class.

References and Recommended Background Readings

Bourne, P., and Light, E. Alcohol problems in blacks and women. In: Mendelson, J., and Mello, N., eds. Diagnosis and Treatment of Alcoholism. New York: McGraw-Hill, 1979. pp. 84-115.

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Biophysical and Psychosocial Consequences of Alcoholism

The nurse practitioner needs to know the symptomatology of the direct and indirect physical and psychosocial effects of alcohol consumption. This knowledge will heighten the nurse practitioner's awareness of clients who have serious drinking problems and will lead to earlier identification and diagnosis of alcoholism.

Alcohol directly and indirectly affects every body system, producing both acute and chronic changes. Ingesting even small amounts of alcohol, for example, will cause temporary liver swelling and tenderness and sensory-motor slowing. Used over long periods of time and in large quantities, alcohol can cause irreparable damage to body organs. Used in this manner, alcohol interferes with normal daily activities and interpersonal relationships. Often this results in major psychological and social problems for the individual and family.

Alcoholism can continue for years before permanent disability or death ensues. Early intervention could halt these deleterious effects. In-depth knowledge of the consequences of alcoholism is vital if the nurse practitioner is to analyze and synthesize appropriately those cues indicative of pathology.

Learning Objectives

On completing this unit, the nurse practitioner will be able to

- Discuss the metabolism of alcohol and describe metabolic abnormalities caused by chronic alcohol use
- Discuss particular physiological phenomena related to alcohol ingestion, including intoxication, tolerance, dependence, and withdrawal
- Describe pertinent pathophysical consequences of alcohol on the body systems
- Discuss specific nutritional complications of alcoholism
- Discuss the interaction of alcohol with other drugs
- Describe alcohol's pathology as it affects the individual psychologically and socially
- Discuss the consequences of alcoholism within the family system

Content Outline

I. Biophysical Consequences of Alcohol Use and Alcoholism

  A. Metabolism (Estes et al. 1980; Mendelson and Mello 1979)

    1. Metabolic process that takes place in one of three enzyme systems in the liver

      a. Primary system is the alcohol dehydrogenase system (ADH) in which

        (1) alcohol is changed into acetaldehyde by alcohol dehydrogenase and the cofactor nicotinamide adenine dinucleotide (NAD)

        (2) acetaldehyde is then converted into acetyl coenzyme A by acetaldehyde dehydrogenase in the presence of NAD; the acetyl coenzyme A then enters the Krebs cycle, is converted to fatty acids and cholesterol, and eventually becomes carbon dioxide and water

        (3) zero-order kinetic metabolism occurs, converting a fixed amount of alcohol in a limited period in the nonaddicted individual at an oxidation rate of approximately 1 oz absolute alcohol in 1 hour

b. Microsomal ethanol oxidizing system (MEOS) metabolizes alcohol

(1) MEOS is activated by exposure to alcohol, especially in addicted individuals

(2) this first-order kinetic metabolism is able to metabolize large quantities of alcohol and, the greater the blood alcohol concentration, the faster alcohol is metabolized

c. Catalase metabolizing system plays an insignificant role in alcohol metabolism

2. Effects of alcohol oxidation on metabolism

a. Metabolic abnormalities result from

(1) generation of reducing equivalents (alteration of the NADH/NAD ratio when transfer of H+ to NAD)

(2) increased production of acetaldehyde and acetate, which are toxic metabolites

b. Hyperuricemia

(1) condition is due to the effects of excess blood lactate on renal excretion of uric acid

(2) ethanol metabolism results in increased lactatepyruvate ratio (linked to redox state of cell [NADH/NAD])

(3) condition is reversible upon alcohol withdrawal

c. Steatosis and hyperlipidemia

(1) ethanol suppresses fatty acid oxidation, increases hepatic lipoprotein synthesis, and increases cholesterol synthesis

(2) fat derived from diet or endogenous synthesis is deposited in liver

(a) initially lipid accumulation is offset by increased synthesis and release of lipoprotein

(b) advanced liver damage is indicated by loss of distinct alpha and pre-beta lipoprotein bands, and by decreased levels of plasma cholesterol esters

d. Alcoholic ketoacidosis

(1) ketonemia

(a) condition is induced by alcohol in absence of nutritional deficits

(b) alteration in mitochondrial function mediates ketogenesis

- (2) ketoacidosis
  - (a) condition usually occurs in female alcoholics with nausea, vomiting, low food intake, and recent drinking binge
  - (b) physical findings include confusion, Kussmaul respirations, dehydration
  - (c) laboratory findings include depressed sodium bicarbonate, widened anion gap, elevated serum ketones

e. Carbohydrate metabolism

- (1) effects of ethanol are dependent on hepatic reserves of glycogen
  - (a) with adequate reserves
    - (i) ethanol enhances glycogenolysis and raises serum glucose
    - (ii) effects can be mediated by catecholamine secretion or decreased peripheral use of glucose
  - (b) with depleted reserves, symptomatic hypoglycemia may result from alcohol consumption
- (2) hypoglycemia may result from the limiting of the availability of gluconeogenic precursors linked to NADH/NAD
  - (a) amino acid conversion to glucose is inhibited
  - (b) symptoms occur as in diabetic hyperinsulinism

B. Particular physiological phenomena (Estes et al. 1980; Mendelson and Mello 1979)

1. Intoxication

a. Ethanol is a central nervous system (CNS) depressant that alters thought, motor ability, and behavior

b. Intoxication is an acute response to ethanol ingestion

c. The following are blood alcohol levels (BAL) and symptomatology for nonaddicted persons:

- (1) 0.05 percent (50mg per 100ml)
  - (a) alcohol is perceptible in the blood
  - (b) person is not under the influence, appears normal
- (2) 0.10 percent (100mg per 100ml) is generally legal evidence of intoxication, with person showing

        - (a) emotional lability
        - (b) slight muscular incoordination, slowed reaction time, ataxia
    - (3) 0.15 percent is considered intoxicated, with
        - (a) sensory disturbances: diplopia, slurred speech, vertigo
        - (b) confusion
        - (c) staggering gait
    - (4) 0.20 percent is considered acutely intoxicated, with
        - (a) marked decrease in response to stimuli
        - (b) muscular incoordination
        - (c) nausea, vomiting
        - (d) drowsiness, stupor
    - (5) 0.30 to 0.40 percent is severely depressed state, with
        - (a) unconsciousness
        - (b) impaired deep tendon reflexes (DTRs)
        - (c) peripheral vascular collapse
        - (d) seizures
    - (6) 0.50 percent: death occurs because of respiratory arrest that results in cardiac arrest
- d. Other factors influence BAL
    - (1) alcohol is more rapidly absorbed on an empty stomach or when taken with a carbonated beverage
    - (2) individuals with more muscle mass can ingest more alcohol without becoming intoxicated because
        - (a) muscle mass has more water to dilute the alcohol
        - (b) adipose tissue is not as available as muscle for diluting alcohol (less water)
    - (3) persons addicted to alcohol exhibit
        - (a) physiological tolerance
        - (b) fewer symptoms with a high BAL

e. Beverage equivalents to 1 oz absolute alcohol include
   - (1) 2.5 oz 80-proof whiskey
   - (2) 24 oz beer (4.5%)
   - (3) 10 oz table wine (10%)
   - (4) 5 oz sweet wine (20%)

2. Tolerance
   - a. Nervous system response to a chronically high BAL includes
     - (1) over time, more alcohol is required to obtain desired effects
     - (2) individual having high BAL but no corresponding symptomatology
   - b. Reserve tolerance
     - (1) condition is seen in alcohol-induced, end-stage liver disease
     - (2) liver cannot detoxify previous amounts of alcohol
     - (3) small amounts of alcohol may be severely intoxicating
   - c. Cross tolerance
     - (1) condition develops between alcohol and other CNS depressants
     - (2) an individual addicted to alcohol can rapidly acquire a dependence on a CNS depressant; the reverse is also true
     - (3) physiological resistance to detoxification is often seen in concomitant drug use

3. Physiological dependence
   - a. The CNS adapts to the sedative effect of alcohol
     - (1) the physiologically dependent person requires alcohol to function
     - (2) without alcohol, withdrawal symptomatology will ensue
   - b. When withdrawal syndrome occurs, an individual is considered physiologically dependent

4. Withdrawal syndrome (Estes et al. 1980; Feinberg 1980; Mendelson and Mello 1979; McElmeel and Di Denti 1980)
   - a. Syndrome occurs when large quantities of alcohol have been consumed over a period of time and consumption is suddenly decreased or halted

- (1) syndrome is considered a state of hyperexcitability
- (2) "rebound" phenomena occur in previously chronically depressed nervous tissue

b. Severity of withdrawal depends on

- (1) quantity of alcohol consumed: large amounts increase risk
- (2) duration of last drinking episode: the longer the episode the greater the risk
- (3) concurrent use of CNS depressants, which worsens and prolongs withdrawal
- (4) general health status
  - (a) ill health and debilitation increase risk of mortality 25 percent
  - (b) pneumonia is associated with an increased mortality rate
  - (c) chronic, poorly treated illness will be exacerbated: diabetes, cardiac disease, hypertension, anemia
- (5) history of severe withdrawal episodes
  - (a) risk of severe withdrawal is increased with previous severe episode
  - (b) seizure during withdrawal is more likely when the history shows previous seizure(s) during withdrawal

c. Two phases of withdrawal

- (1) minor (early) withdrawal: first phase
  - (a) course
    - (i) onset occurs a few hours after cessation of alcohol intake
    - (ii) peak occurs after 24 to 36 hours
    - (iii) condition rapidly dissipates
  - (b) symptoms
    - (i) early indications are tremor, diaphoresis, anxiety, anorexia, insomnia
    - (ii) alcohol withdrawal seizures
      - — seizures occur 7 to 48 hours after abstinence or reduced alcohol intake

- seizures are related to a decreased seizure threshold and to increased neural activity secondary to respiratory alkalosis
  - grand mal seizure may occur with loss of consciousness
  - withdrawal seizures can exist in individuals with no seizure history and normal baseline electroencephalogram (EEG)
  - after completion of withdrawal, the individual can be expected to remain seizure free
- seizures take the form of status epilepticus in 3 percent of clients, which suggests a more complex etiology: sedatives, meningitis, subdural hematoma
- seizures may occur as focal seizures, suggesting CNS injury
- seizures may result from preexisting seizure disorders that have been exacerbated by alcohol intake and withdrawal

(iii) disordered perception

- hallucinations occur of audio, visual, mixed nature
  - hallucinations are benign in nature
  - hallucinations are not associated with panic or paranoia
  - individual is communicative, oriented, rational, with memory intact
- mild disorientation ensues
  - disorientation occurs in initial tremor state
  - condition is brief, minimal
  - time disorientation is most common
  - condition may be exacerbated (look for increasing disorientation predictive of delirium tremens)

(iv) tachycardia reflecting toxicity

- 120 to 140 beats per minute is common
- heartbeat is useful in monitoring progress

- pulse returns to normal at completion of withdrawal
- elevation may signal impending delirium tremens

(v) other symptoms: nausea, vomiting, diarrhea, generalized weakness, elevated blood pressure

(2) major withdrawal (delirium tremens): this second phase is secondary to respiratory alkalosis and hypomagnesemia

(a) course

(i) onset occurs 40 to 60 hours after cessation or reduction of alcohol consumption

(ii) peak occurs after 80 to 90 hours

(iii) phase may persist 2 to 3 days

(iv) phase often ends abruptly

(b) seriousness of condition

(i) hospitalization is required

(ii) condition occurs in 4.5 to 8 percent of all persons withdrawing from alcohol

(iii) mortality rate is 15 percent

(c) symptoms

(i) profound disorientation and perception disorder is hallmark

(ii) psychomotor activity is increased; extreme restlessness, gross tremor, hallucinations

(iii) autonomic activity is increased: fever, tachycardia, profuse diaphoresis

(iv) convulsions are absent

C. Pathophysiology of body systems (Estes et al. 1980; Mendelson and Mello 1979; Seixas 1980)

1. Consequences of alcohol use

a. Large group of pathologies have been identified as alcohol engendered

b. Accumulation of high levels of alcohol in bloodstream results in

(1) direct and indirect toxic effects in tissues

    - (2) malnutrition secondary to dysfunction or synthesis inhibition
  - c. All body systems are vulnerable
  - d. Degree of pathology is dependent on
    - (1) individual variances
    - (2) intensity and duration of intake
    - (3) specific vulnerability of body system

2. Body systems
  - a. Gastrointestinal (Estes et al. 1980; Fenster 1977): alcohol is a direct irritant to mucosal tissue, producing inflammation, damage, chronic bleeding, and malabsorption
    - (1) mouth and throat
      - (a) increased incidence of oral pharyngeal cancer
      - (b) increased cancer risk from synergistic action of smoking with alcohol
      - (c) glossitis
      - (d) parotid gland enlargement
    - (2) esophagus
      - (a) increased incidence of cancer
      - (b) injury to esophageal lining
        - (i) direct irritant effects
        - (ii) alcohol-induced vomiting
      - (c) alcohol-induced syndromes
        - (i) Mallory-Weiss Syndrome
          - — gastroesophageal junction mucosal laceration
          - — presentation: painless hematoemesis following alcohol ingestion and severe vomiting
          - — diagnosis confirmed by endoscopy
          - — self-limited if vomiting is controlled
          - — common cause of hematoemesis or "gastric bleeding"

(ii) Boerhaave Syndrome

— frank rupture of lower esophagus with gastric fluid leakage

— presentation: severely painful hematoemesis preceded by coughing, lifting, seizures, vigorous vomiting

— possible outcome: shock and death

(d) esophageal varices

(i) secondary to liver damage producing portal hypertension

(ii) varices vulnerable to rupture

(iii) possible outcome: severe hemorrhage and death

(iv) common cause of hematoemesis

(3) stomach: erosive gastritis

(a) mucosal cell barrier destroyed by alcohol

(b) presentation: gastric distress, nausea, vomiting, distention, bleeding

(c) not the most common cause of hematoemesis

(d) risk of gastric ulceration increased with simultaneous ingestion of alcohol and aspirin

(4) intestines

(a) injury to mucosa resulting in malabsorption

(b) inflammatory processes (enteritis, colitis) resulting from alcohol ingestion

(c) hemorrhoids resulting from portal hypertension

(5) liver (major target organ of alcohol pathology)

(a) hepatotoxicity

(i) result of excess alcohol consumption

(ii) inability of good nutrition to protect against serious tissue damage

(iii) linear relationship demonstrated for alcohol intake and liver damage

(b) three common liver pathologies (these pathologies exist as single entities, in combination, or in progression)

(i) alcohol fatty liver

- secondary to free fatty acid accumulation in liver cells forming fat deposits
- present also in nonaddicted, moderate-drinking persons
- remobilization of fat occurring with cessation of alcohol use
- rarely symptomatic
- objective findings: hepatomegaly, slightly elevated liver function tests (LFT)
- presentation: acute and severe abdominal pain and jaundice in binge drinkers

(ii) alcoholic hepatitis

- secondary to inflammatory necrosis of liver cells, producing cell death and fibrosis
- condition of serious, life-threatening nature
- clinical presentation: hepatomegaly, jaundice, hepatic pain, fever, elevated liver function tests (LFTs), leukocytosis, and asitia
- degree of reversibility dependent on severity and chronicity, with
    - minimal reversibility if hepatic structure is destroyed
    - 30 percent mortality early in course
    - many clients proceeding to develop cirrhosis

(iii) alcoholic cirrhosis

- advanced cell necrosis, with
    - scarring, nodule formation, altered hepatic structure
    - essentially irreversible condition

- clinical picture of
    - o portal hypertension, ascites, edema
    - o firm, nodular, possibly enlarged liver
    - o enlarged spleen in some cases
    - o abnormal serum chemistry: hyperbilirubinemia, hypoprothrombinemia
- late stage processes, with
    - o esophageal varices
    - o hepatic encephalopathy, coma: insufficiency produces high blood ammonia levels; neuromotor, mental, and behavioral aberrations are present; asterixis (flapping tremor) may herald onset of coma; death ensues

(6) pancreas

(a) decrease in amount of pancreatic secretions, increase in viscosity

(b) obstruction of pancreatic duct

(c) alcohol etiology in approximately 50 percent of pancreatitis cases

(d) acute pancreatitis

(i) occurrence after 1 to 2 days of heavy drinking

(ii) presentation: severe upper abdominal pain radiating to back, nausea, vomiting, ileus, fever

(iii) diagnostic confirmation: elevated serum amylase

(e) chronic pancreatitis

(i) insidious onset, possible history of vague chronic pain

(ii) presentation: pancreatic gland insufficiency

- exocrine component: fat malabsorption; associated weight loss; malnutrition; foul-smelling, bulky stools; diarrhea
- endocrine component: glucose intolerance

b. Neurological system (Estes et al. 1980; Smith 1977b): extensive effects of alcohol include direct toxic pathologies, malnutrition pathologies, and nervous system injuries secondary to trauma while intoxicated

- (1) central nervous system phenomena
    - (a) intoxication, physiological dependence, withdrawal
    - (b) blackouts characterized by
        - (i) amnesia with concurrent high BAL
        - (ii) unretrievable short-term memory loss
    - (c) premature brain cell aging
    - (d) permanent brain damage
- (2) peripheral nervous system phenomena: neuropathy
    - (a) secondary to thiamine deficiency
    - (b) presentation with
        - (i) progressive numbness, pain, paresthesias in distal extremities
        - (ii) pattern: bilateral, symmetrical
        - (iii) sensory loss preceding motor dysfunction, weakness, ataxia
        - (iv) stocking-glove distribution
        - (v) diminished or absent deep tendon reflexes (DTRs), vibratory and position sense
- (3) sleep disturbances
    - (a) alteration of normal sleep patterns, including
        - (i) REM deprivation during drinking followed by REM deprivation upon cessation
        - (ii) absence of stage 4 (deep sleep) in alcoholic persons whether actively drinking or not
        - (iii) decrease in stage 3 sleep during drinking, with return to normal on cessation
        - (iv) no alteration of stage 1 and 2 sleep
    - (b) presentation: insomnia, restlessness, frequent awakening, night terrors

(4) Wernicke-Korsakoff Syndrome: disorder secondary to thiamine deficiency (Feinberg 1980)

- (a) Wernicke encephalopathy
  - (i) hemorrhagic brainstem and hypothalamic lesions
  - (ii) presentation
    - — progressive external ophthalmoplegia
      - o horizontal nystagmus
      - o bilateral rectus palsies
      - o progress to complete paralysis
    - — concomitant ataxia, confusion, disorientation
  - (iii) treatment
    - — thiamine replacement: reverses symptoms in early stages
    - — failure to treat: results in Korsakoff's psychosis
- (b) Korsakoff's psychosis
  - (i) neuronal lesions (more diffuse than in Wernicke encephalopathy)
  - (ii) presentation
    - — recent memory loss
    - — poor insight and judgment
    - — confabulation
  - (iii) treatment
    - — thiamine replacement
    - — often slow response to treatment
    - — potential for permanent residual damage

(5) Organic Brain Syndrome (Dementia): several etiologies including alcoholism

- (a) destruction of neurons in progressive, insidious pattern
- (b) presentation

(i) early symptoms

- fatigue, listlessness, loss of interest, depression, anxiety, agitation

- personality changes: social withdrawal, irritability, petulance, moral laxity

(ii) progression in symptoms

- confusion, disorientation, recent memory loss, poor judgment, lack of insight

- spasticity of lower extremities, scissor gait, fine picking movements

(iii) late stages: custodial care required

(6) other degenerative syndromes in late-stage alcoholism

(a) alcoholic cerebellar degeneration

(b) Marchiafava-Bignami disease

(c) central pontine myelinolysis

(7) alcoholic pellagra

(a) secondary to niacin deficiency

(b) presentation

(i) psychiatric disturbance: confusion, hallucinations, depression, delirium

(ii) dermatitis

(iii) gastrointestinal disturbance: glossitis, diarrhea, stomatitis, constipation

c. Cardiovascular system (Estes et al. 1980; Morton 1978)

(1) direct toxic effects

(a) depression of cardiac muscle by large quantities of alcohol, with:

(i) decreased cardiac output

(ii) increased lactic acid to periphery

(iii) dilation of vessels

(iv) compensatory tachycardia

(b) cardiomyopathy

  (i) resulting from prolonged alcohol abuse (>5 years)

  (ii) permanent alteration of cardiac structure

  - accumulation of triglycerides
  - inflammation
  - interstitial fibrosis

  (iii) extensive hemodynamic alterations

  (iv) presentation

  - early symptoms: exertional and nocturnal dyspnea, basilar rales, elevated blood pressure and pulse
  - progression in symptoms
    - o rate and rhythm disturbances: atrial fibrillation, premature ventricular contraction (PVC), premature atrial contraction (PAC), paroxysmal atrial tachycardia (PAT), ventricular tachycardia
    - o symptomatic congestive heart failure: cardiomegaly; cough, chest pain, shortness of breath, pulmonary and peripheral edema; ascites, prominent pulsation of enlarged liver

(2) indirect toxic effects

(a) conductive heart disease

  (i) increased excretion of magnesium, potassium, sodium, and chloride induced by alcohol

  (ii) arrhythmias produced by electrolyte imbalance

(b) cardiac problems exacerbated by overhydration

  (i) secondary to rebound hyperexcretion of antidiuretic hormone (ADH)

  - ADH is inhibited, wi[illegible]sing and stabilized BAL promoting diuresis
  - ADH rebounds, with falling BAL inhibiting diuresis

  (ii) possible acute heart failure caused by overhydration

(c) withdrawal problems

- (i) stressed cardiovascular system
- (ii) exacerbation of underlying hypertension or vessel disease
- (iii) possible precipitation of congestive heart failure (CHF) or acute myocardial infarction (AMI)
- (iv) possible shock, standstill, ventricular flutter or fibrillation produced by severe, prolonged withdrawal

(d) beriberi heart disease

- (i) alcohol-induced thiamine deficiency
- (ii) significant reduction of peripheral vascular resistance, with increased cardiac output and decreased circulation (opposite of cardiomyopathy)
- (iii) presentation: high output CHF, peripheral neuropathy
- (iv) outcome: potentially fatal

(e) hypothermia problems

- (i) alcohol-induced peripheral vascular dilation causing heat loss
- (ii) exposure plus alcohol consumption resulting in hypothermia

d. Respiratory system (Estes et al. 1980)

(1) direct toxic effects

(a) impairment in defense mechanisms of lungs

- (i) diminished protection against airborne and noxious stimuli
- (ii) diminished ability to clear secretions and bacteria from lung passages
- (iii) depression of cough reflex, increasing risk of aspiration

(b) increased incidence of infections and airway obstruction

(2) indirect toxic effects

(a) immune system suppression

- (i) increased susceptibility to infections
- (ii) high incidence of tuberculosis, pneumonia

(b) exacerbation of lung problems by smoking, causing permanent damage

e. Genitourinary system

(1) direct toxic effects on testes

(a) decreased plasma testosterone levels, infertility, atrophic testes, inadequate secondary sex characteristics

(b) presentation: impotence, decreased libido, decreased beard growth, prostatic atrophy

(c) concurrent hyperestrogenism in some cases: gynecomastia, decreased body hair, hypogastric and pelvic fat pads

(2) direct effects on female genitourinary system

(a) less extensive, inconclusive research

(b) apparent increased incidence of gynecological problems: menstrual irregularities, dysmenorrhea, abortions, premature births, stillbirths, hysterectomies

(3) indirect effects: both sexes demonstrate increased incidence of genitourinary infections

f. Musculoskeletal system (Estes et al. 1980; Smith 1977a)

(1) direct toxic effects

(a) skeletal muscle myopathy, muscle breakdown

(b) clinical entities

(i) subclinical

— client is often asymptomatic

— history may be positive for transient muscle cramps, weakness, dark urine

— lab data may be only indication: elevated muscle enzymes measured by serum glutamic oxaloacetic transaminase (SGOT), lactate dehydrogenase (LDH), creatine phosphokinase (CPK)

(ii) acute

— patient usually presents following acute alcohol debauch

— presentation discloses:

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            - symptoms: weakness of limb girdle and musculature, muscle pain, tenderness, edema
            - lab data: markedly elevated muscle enzymes
        - condition may precipitate acute renal failure secondary to myoglobin release into circulation
    - (iii) chronic
        - condition may occur either as consequence of acute episodes or without previous history of such episodes
        - presentation discloses:
            - limb-girdle muscle weakness and wasting
            - no pain, tenderness, or elevated muscle enzymes

- (2) indirect toxic effects
    - (a) high incidence of skeletal and muscular trauma secondary to intoxication
    - (b) osteoporosis secondary to calcium depletion, poor diet, decreased activity
    - (c) osteonecrosis of hip
        - (i) rare finding secondary to hyperlipidemia: fat emboli blocking blood supply to femoral head and causing necrosis
        - (ii) presentation: severe, often bilateral hip pain, limping; no history of symptoms of arthritis

g. Integumentary systems (Estes et al. 1980)

- (1) lesions secondary to liver pathology
    - (a) linear excoriations secondary to pruritis: an early symptom of impaired liver function that may appear 2 years prior to other symptomatology
    - (b) gray skin pigment
    - (c) jaundice
    - (d) cyanosis
    - (e) dorsal tongue furrows
    - (f) scant body hair

            - (g) spider nevi
            - (h) palmar erythema
        - (2) lesions secondary to malnutrition
            - (a) glossitis secondary to folate deficiency
            - (b) purpura secondary to impaired prothrombin production
            - (c) poorly healing lesions
        - (3) lesions exacerbated by chronic alcohol consumption
            - (a) rhinophyma
            - (b) acne rosacea
            - (c) psoriasis
            - (d) seborrhea dermatitis
            - (e) "wine sores"
            - (f) infection, coincident with poor hygiene or impaired immune system
            - (g) Dupuytren's contractures

h. Hematopoietic system (Steinberg and Hillman 1980)

- (1) direct toxic effects
    - (a) interference with maturation of all marrow cellular elements: red blood cells (RBCs), white blood cells (WBCs), platelets
        - (i) blockage of WBC synthesis by alcohol
            - — resultant leukopenia
            - — impaired leukocyte mobilization, function, and chemoactive properties, with increased vulnerability to infection
        - (ii) blockage of thrombocyte maturation
            - — decreased platelet life span
            - — inhibited platelet function
            - — reduced clotting factor activity

(iii) hemosiderosis: increase in tissue iron stores resulting from iron-rich alcohol

(b) prevention of pyridoxal phosphate covergence to active conger B_6

(i) megaloblastic anemia

(ii) sideroblastic anemia

(2) indirect toxic effects

(a) folic acid deficiency

(i) alcohol-induced intestinal mucosal block of folate

(ii) additional blockage at cellular level

(b) iron deficiency anemia

(i) secondary to alcohol-induced frank bleeding: gastritis, varices, hemorrhoids

(ii) no block to intestinal mucosal absorption

D. Nutritional considerations (Worthington 1977)

1. Nutrient content of alcohol

a. Carbohydrate-calorie yield is 7 calories per gm

b. Alcohol does not supply any essential nutrients

2. Malnutrition

a. Alcohol displays food containing protein, vitamins, minerals

b. Alcohol can supply most of daily caloric needs, so that

(1) hunger is diminished

(2) weight is maintained (muscle mass decreases with increase in adipose tissue)

c. Alcohol directly affects nutrients by blocking absorption, modification, storage

d. Inflammation of gastric, intestinal mucosa prevents absorption

e. Progressive liver damage plays key role in avitaminosis and malnutrition

3. Specific deficiencies

a. Thiamine (most common deficiency): directly destroyed, used in alcohol metabolism

b. Folic acid: blocked at intestinal and cellular level

c. B_6: production of active form inhibited

d. Niacin: directly destroyed, used in alcohol metabolism

e. Riboflavin: directly destroyed, blocked at intestinal level

f. Protein: profound modification of amino acid metabolism

g. Iron: diminished through bleeding

h. Minerals: distortion in metabolism affecting magnesium, calcium, potassium, zinc

E. Drug and alcohol interactions (Estes et al. 1980)

1. Effects: alcohol used concomitantly with drugs may cause inhibitive, addictive, synergistic effects

2. Polydrug use

a. Use of polydrugs is so common as to be a societal norm

b. Elderly, adolescents, women are groups at risk

II. Psychological Consequences of Alcoholism (Estes et al. 1980)

A. Defense mechanisms

1. Protective devices

a. Alcoholic person uses defense mechanism to ameliorate reality of alcoholism

b. Protective devices permit continuing, unyielding use of alcohol

c. Alcoholic person fears life without alcohol would be unbearable

d. Breakdown of defense mechanisms is difficult

(1) breakdown of defense mechanisms is more likely to occur in crisis event or when alcoholic person is vulnerable and use of defenses is diminished

(2) crisis can be a time to motivate to treatment

(3) once crisis is past, alcoholic person often rebounds to previous drinking behavior

2. Denial

   a. Denial is hallmark of alcoholic behavior

   b. This defense is powerful, often impenetrable

   c. Denial serves to protect self by negating reality

      (1) reality is denied first to self, then to others

      (2) denial of reality cannot be considered lying, as the person is convinced he or she is not alcoholic

      (3) the illness pathology supports the delusion

   d. Denial helps the alcoholic person avoid guilt, shame, awareness of behavioral consequences, low self-esteem

   e. Others become involved in denial

      (1) family, friends, health providers get caught up in denial system

      (2) they too can deny the alcoholism and protect the alcoholic individual

      (3) the consequence is perpetuation of illness and delay in diagnosis and treatment

3. Repression, suppression

   a. Selected memory recall results from this defense mechanism

   b. Anxiety-producing thoughts, impulses are controlled

   c. Psychological safety is maintained

4. Projection

   a. Negative thoughts and blame become deflected

   b. To keep ego intact, the alcoholic person superimposes negative thoughts and blame on someone else

5. Rationalization

   a. Large repertoire of reasons for past and continued drinking is developed

   b. Rationalization is often a highly developed mechanism in alcoholic persons

B. Affective responses: loneliness, depression

1. Affective responses may precede or result from alcoholism

2. Alcohol exacerbates these feelings

        a. The alcoholic person encounters interpersonal problems, destroyed relationships, avoidance, hostility

        b. Low self-esteem, poor social skills, inconsistent behavior contribute to loneliness

        c. Feelings of worthlessness, hopelessness, anger, frustration contribute to depression

        d. Person drinks to relieve these feelings

            (1) alcohol is CNS depressant

            (2) further depression results

    3. Suicide rate is higher among alcoholics than general population

        a. Women: 23 times higher

        b. Men: 22 times higher

III. Family Consequences of Alcoholism (Black 1981; Cork 1969; Estes and Hanson 1976; Jackson 1956)

A. Alcoholism as a family illness

    1. Effect of alcoholism on family system

        a. Degree of distress within family system varies

        b. Effect of alcoholism is a potentially dysfunctional family

    2. Difficulties of maintaining homeostasis when alcohol is a stressor

        a. Adaptation is made to the disruption and conflict

            (1) communication patterns change with members withdrawing from one another

            (2) roles shift and readjust to accommodate the alcoholic family member

            (3) sexual interactions change

        b. Continual adaptation to stressors of alcoholism may be detrimental

            (1) adaptive efforts drain energy needed for other family needs and tasks

            (2) individual members are emotionally, physically neglected

            (3) family may inadvertently support continued drinking

- (a) accommodation to alcoholic member may assure emotional, physical security for other members
- (b) alcoholic member may be playing a role the family needs
  - (i) alcoholic person is the identified patient
  - (ii) other family issues can be avoided, diminished

c. Family adjustment to alcoholism occurs in stages (see Appendix E)

- (1) attempts are made to deny the problem
- (2) attempts are made to eliminate the problem
- (3) disorganization ensues
- (4) attempts are made to reorganize in spite of the problem
- (5) reorganization of nonalcoholic family members occurs
- (6) recovery of the alcoholic person brings on subsequent reorganization of the whole family

B. Spouse of the alcoholic person

1. Family stress: deep entrenchment of spouse in managing the family to maintain homeostasis

a. Spouse takes on both parental roles

b. Spouse feels inadequate, helpless, alone

- (1) no energy is left over to deal with family members' needs, including own
- (2) spouse feels unsure of how, when, if to seek help
- (3) spouse often has isolated family and self from outside support systems

2. Treatment barriers: potential difficulty in sharing problems with nurse practitioner

a. Clues to an alcoholic family situation may be subtle, including

- (1) economic impairment
- (2) mention of conflict, violence, separation, divorce, sexual problems
- (3) feelings of being isolated, overburdened with family responsibilities
- (4) expression of tearfulness, anxiety, depression; exhibition of suicidal ideation

    - b. Nurse practitioner needs high index of suspicion
    - c. Direct inquiries are needed about whether alcoholism is the basis for difficulties

C. Children with alcoholic parents

- 1. Effects
    - a. Effects are variable, depending on age, personality of child, severity of alcoholism, other support systems
    - b. Specific effects differ little from those seen in any unhappy home
- 2. Problems encountered by children
    - a. Emotional neglect
        - (1) neglect is most commonly encountered problem
        - (2) parental overinvolvement in alcohol dynamics leaves little time, energy to meet children's needs
        - (3) parents may demonstrate inconsistent behavior depending on degree of crisis
            - (a) neglect occurs when drinking is intense
            - (b) attention increases when drinking is minimal
        - (4) children feel they are bad or are to blame for family problems
    - b. Family conflict
        - (1) home life is stressful and often erupts into violence
        - (2) children learn to deal with problems through conflict, violence
        - (3) children are reluctant to bring friends home and become isolated from peers
        - (4) children are at high risk for physical and sexual abuse
    - c. Role shift, role confusion
        - (1) parental role remains unfilled
            - (a) alcoholic parent does not participate in parental role
            - (b) nonalcoholic parent attempts to fill both roles
                - (i) burden becomes too great without support

(ii) parent shifts role to children

(2) healthy models to emulate don't exist for children

(a) children find it difficult to emulate either parent

(b) role confusion exists

d. Risk of developing alcoholism: children with an alcoholic parent are 58 percent more likely to develop alcoholism than other children

3. Behaviors encountered in children from alcoholic families

a. Acting out: temper tantrums, fighting with peers, trouble in school, truancy, involvements with police, courts

b. Poor self-esteem, little trust in others

c. Low energy, little enthusiasm

d. Few friends, social isolation

e. Overdeveloped sense of responsibility, perfectionism

IV. Social Consequences of Alcoholism (Estes et al. 1980)

A. Economic difficulties

1. Little money: income spent on alcohol leaves little for necessities

2. Job problems: alcoholic person may face demotion, loss of employment

3. Welfare dependencies: family turns to the welfare system for support

B. Legal difficulties

1. Driving while intoxicated: statistics indicate an alcohol component in one-half of traffic fatalities, one-third of traffic accidents

2. Assaults, fights while intoxicated

3. High association of alcohol with crime

a. 83 percent of offenders in prison or jail report alcohol involvement in their crimes

b. Frequent offenses are robbery, homicide, and rape

Teaching Methodologies

Because of the extensive material covered in this unit, lectures should focus primarily only on key areas: metabolism, physiologic effects; the gastrointestinal, cardiovascular, neurological, and musculoskeletal systems; and psychosocial consequences. Students will need to rely on supplemental readings for additional knowledge.

It is assumed that the student will have concomitant clinical experiences during which he or she may observe the pathological consequences of alcoholism. As an optional assignment, the student could be asked to choose one area of pathology, review the literature, and write a paper, thus gaining some in-depth knowledge of that particular topic.

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Part Two: Diagnosis of Early and Chronic Alcoholism

The Diagnostic Process

This unit focuses on the assessment and diagnosis of alcoholism in a primary care setting. The interview is emphasized as a means to obtain needed data and promote rapport. Particular attention will focus on clues in the subjective and objective data that can suggest alcoholism pathology. Concern for subtle, often missed clues will enhance an early diagnosis of an alcohol problem. The "Criteria for the Diagnosis of Alcoholism" (Appendix D) is used to help synthesize the assessment data and formulate a diagnosis. In addition, discussion of the diagnosis with the alcoholic person and his or her family is considered.

Learning Objectives

On completing this unit, the nurse practitioner should be able to

- Use awareness of alcoholism pathology to assess possible alcoholism
- Use interview techniques to acquire pertinent data on alcohol use and abuse
- Gather and analyze significant subjective and objective data indicative of alcoholism
- Synthesize findings to formulate a diagnosis of alcoholism
- Develop an approach to the alcoholic person and family that will encourage treatment and recovery

Content Outline

I. Approach to the Interview (Brammer 1978; Clark 1980; Estes et al. 1980)

   A. General approach

      1. Be alert to possibility of alcohol problems in all population groups (prevalence rates are high, with alcoholism affecting approximately one-fifth of clients)

         a. Consider alcoholism as cause of problems in clients with

            (1) pervasive illness

            (2) subtle, early pathology

        - (3) symptoms that may be mimicking other illnesses
        - (4) incongruent findings, unusual patterns of illness
    - b. Consider symptomatology in family members as possibly alcohol engendered
- 2. Inquire about the role of alcohol regarding the presenting problems
    - a. Use helpful tools for determining alcohol problems in the general population
        - (1) CAGE: series of four diagnostic questions to be incorporated into patient substance use history (reprinted in Estes et al. 1980, p. 101)
        - (2) Short Michigan Alcoholism Screening Test (SMAST) (Appendix C)
    - b. Use helpful tools for determining alcohol problems in the family (for examples, see Estes et al. 1980, pp. 224-227)
- 3. Pursue suspicions with further questioning
    - a. Take a sensitive, open, direct approach
    - b. Engender trust
    - c. Consider denial and hostility as factors that may deter data collection
    - d. Use family and significant others to corroborate data
        - (1) discuss this information with client
        - (2) interview separately and together
- 4. Compare findings to clinically useful definition of alcoholism (Bissell 1980)
    - a. Make a tentative diagnosis if individual repeatedly ingests alcohol despite own definitive best interest
    - b. Consider the diagnosis confirmed when alcohol is used compulsively in spite of problems with family, job, health, and law

B. Interviewing styles

- 1. Direct questioning requiring factual responses
    - a. Frame questioning within context of other drug use (caffeine, tobacco, other drugs) to make issue less threatening, more natural
    - b. Use questionnaire or tool that focuses questions
        - (1) expect filling out questionnaire to be less threatening than verbal questions, but verbal questioning allows observation of nonverbal behavior

(2) provide followup of questions whether written or verbal (both forms are valuable)

c. Focus less on amount and frequency, more on effects of alcohol

d. Avoid "why" questions; ask what, how, when, and where

e. Assess verbal responses according to typical client responses when asked about alcohol use

(1) Group I: responds in matter-of-fact manner

- (a) appears to be direct, does not seem threatened
- (b) shows no evidence of problems
- (a) presumably has no problems with alcohol unless
  - (i) exam or family presents differently
  - (ii) denial is operative

(2) Group II: shows some concern about drinking

- (a) describes concerns freely, in straightforward way
- (b) probably has early-stage alcoholism
- (c) needs close, ongoing followup and education

(3) Group III: denies existence of any problem

- (a) attempts to persuade interviewer
- (b) shows practiced response or responds carefully, measuring each word
- (c) uses elaborate denial, rationalization mechanisms
- (d) has middle-stage alcoholism
- (e) needs definitive treatment

(4) Group IV: readily admits problems

- (a) appears open, sad, depressed
- (b) presents history of alcohol treatment
- (c) has late-stage alcoholism
- (d) needs definitive treatment; suicide potential needs to be ruled out

(5) Group V: talks openly about problems

(a) appears nondefensive

(b) states he/she is recovering alcoholic

(c) offers a valuable resource for the clinic

(i) to educate nurse practitioners

(ii) to help with newly diagnosed persons

f. Observe nonverbal responses

(1) pay acute attention to behaviors to elicit nonverbal information

(2) look for typical responses when clients feel threatened: uneasiness, nervousness, withdrawal, sudden change in behavior, hostility, poor eye contact, changing the subject

(3) validate perceptions by confronting behavior

2. Confrontation

a. Use techniques that can facilitate interviewing

(1) need to help client deal with an issue interfering with collaborative process

(2) expect that the client may or may not be aware of impediment

(3) develop a sense of when/which issues need exploration

b. Share observations, perceptions with client

(1) state these matter-of-factly

(2) ask client to verify, to look at behavior as another person sees it, i.e., "I noticed you became quieter and looked away when I asked about your drinking"

c. Realize that the client may feel threatened and may perceive observations as criticism or rejection

d. Know situations in which confrontation is necessary, such as

(1) to move forward an interview that seems stymied

(2) to verify information, validate perceptions

(3) to encourage full participation by client

3. Clarification

a. Use clarification techniques to interpret client's thoughts and problems accurately because

(1) alcohol often creates confusion of thought and anxiety for the client

(2) clients need assistance in focusing on specific events and issues through questioning

(3) what, when, how, where questions will usually be productive ("why" questions should be avoided because they often result in denial and rationalization yielding irrelevant answers)

b. Be persistent, direct, tactful in questioning

c. Avoid overuse of clarification, or client will feel questioning is impertinent, intrusive

4. Empathy

a. Use empathy technique to develop feelings of acceptance, understanding, because

(1) client often experiences low self-worth, isolation, guilt

(2) empathy can engender positive relationship

(a) breaks through desperation

(b) encourages expression, resolution

b. Avoid overuse of empathy because

(1) it can create too close identification with client

(2) it can support current behavior and immobilize the diagnostic process, treatment

C. Nurse practitioner responses to client behaviors

1. Hostility

a. Is expressed nonverbally when patient feels threatened

(1) nurse practitioner can anticipate strong emotional response

(2) practitioner can expect overt anger to be common

(a) hostility may be powerful or in some cases dangerous

(b) practitioner requires skill to deal with client's anger

b. Can interrupt assessment process because

            - (1) nurse practitioner feels uncomfortable pursuing questioning
            - (2) practitioner may avoid further questions about alcohol
        - c. Use techniques that elicit needed information yet maintain rapport
            - (1) temporarily divert questioning to another topic to ease threat, return to subject later
            - (2) share perceptions with client
    - 2. Discounting
        - a. Is used by client to distract from or avoid problem solving
        - b. Makes issues or events seem less significant than in reality
        - c. Creates problems because
            - (1) client comes to believe these words are true
            - (2) interferes with recovery
        - d. Identify this response and pursue expressions to help client focus on specific elements of event or issue
    - 3. Grandiosity
        - a. Is used by client to distract from or avoid problem solving
        - b. Makes issues or events seem less significant than in reality
        - c. Deals in absolutes and generalizations: never, always, no one, everyone
        - d. Creates problems because
            - (1) client believes words are true
            - (2) interferes with recovery
        - e. Identify this response and pursue questions that facilitate accuracy, such as who, when, where, what, how questions

- II. Identification and Treatment of Emergent Condition and Withdrawal (Estes et al. 1980; Jacob and Sellers 1977; McElmeel and Di Denti 1980)
    - A. Initial assessment
        - 1. Rule out life-threatening problems
        - 2. If none exist, proceed through normal assessment pattern

B. Emergent conditions

1. Look for likelihood of trauma, chronic illness, exacerbation of disease in alcoholic person

2. Realize alcohol may confuse clinical picture

3. Obtain pertinent, needed information regarding recent history of trauma, past medical problems, and medication use

4. Initiate treatment of emergent problems

    a. Use physician preceptor

    b. Refer to emergency room

    c. Provide emergency care (by nurse practitioner: protocol is beyond the scope of these curriculum guides)

C. Withdrawal syndrome (Estes et al. 1980; Jacob and Sellers 1977; McElmeel and Di Denti 1980)

1. Assessment

    a. Subjective data

        (1) history of antecedent trauma with head injury or fracture

        (2) medical history: cardiac disease, seizure disorder, gastrointestinal disturbances, liver disease, diabetes

        (3) medications

            (a) prescribed and over-the-counter medicines

            (b) compliance with medications while drinking

        (4) alcohol history

            (a) time of last drink

            (b) amount consumed, duration

            (c) concurrent drug use

            (d) history of seizures in withdrawal

            (e) history of severe withdrawal

    b. Objective data for attention (includes problems to rule out [R/O])

        (1) vital signs including postural blood pressure

- (2) head, ears, eyes, nose, throat (HEENT) - R/O head injury
- (3) lungs - R/O acute respiratory disease
- (4) heart - R/O arrhythmia
- (5) abdomen - R/O acute signs
- (6) skin - observe for diaphoresis, lesions
- (7) neurological - R/O focal signs, R/O Wernicke's encephalopathy: confusion, ataxia, nystagmus, ophthalmoplegia

c. Laboratory data (includes problems to rule out)

- (1) chest x-ray - R/O pneumonia
- (2) blood studies
  - (a) complete blood count (CBC) - R/O severe anemia
  - (b) glucose - R/O hypoglycemia
  - (c) blood urea nitrogen (BUN) - R/O ketoacidosis
  - (d) electrolytes - R/O imbalance
- (3) stool hemoccult - research gastrointestinal bleeding

d. Treatment

- (1) indications for hospitalization
  - (a) medical or surgical condition requiring hospital treatment
  - (b) major withdrawal: delirium tremens
  - (c) tachycardia, severe tremor, extreme agitation
  - (d) fever 38.5°C
  - (e) Wernicke's encephalopathy
  - (f) seizures
    - (i) first generalized seizure
    - (ii) focal seizure
    - (iii) status epilepticus
    - (iv) polydrug user

        - (v) more than two seizures in one withdrawal episode with history of alcohol-related seizures
    - (g) recent head injury with loss of consciousness or focal signs
    - (h) social isolation
- (2) outpatient treatment
    - (a) criteria: no indications for hospitalization, physiologically stable, minor withdrawal symptoms, stable environment for recovery
    - (b) medications
        - (i) thiamine replacement
            - — 100 mg IM/IV stat to counter Wernicke-Korsakoff syndrome
            - — concurrent IV glucose
        - (ii) chlordiazepoxide
            - — 50 to 100 mg by mouth stat
            - — 25 mg 4 times a day for 4 days (give to support person to administer to prevent withdrawal from becoming severe; this drug is not to be used beyond the withdrawal period)
        - (iii) other medications/dietary supplements as necessary
    - (c) no medications: note that one prevalent treatment philosophy is drug-free withdrawal and rehabilitation
    - (d) supportive therapy
        - (i) rest
        - (ii) nonstimulating, accepting environment
        - (iii) fluids, food as tolerated
        - (iv) reassurance
            - — symptomatology: insomnia, restlessness, anxiety, tremulousness, gastrointestinal disturbances such as anorexia, nausea, vomiting, diarrhea
            - — severe symptomatology requires return to clinic or call to provider

            (e) followup

                (i) return to clinic 4 to 5 days later

                (ii) initiate rehabilitation

III. Pertinent Clues in Subjective Data (T. Clark 1979; W.D. Clark 1980; Estes et al. 1980; Morse and Hurt 1979)

  A. Presenting problem

    1. Look for patterns, incongruency, frequent illnesses: Monday "flu," payday gastritis, end-of-month insomnia, nervousness

    2. Consider approach of client

      a. Appears overconcerned about nurse practitioner's welfare

      b. Requests over-the-phone prescriptions

      c. Seems preoccupied with alcohol in conversation, making frequent references to being "bombed," "stoned"

      d. Appears with alcohol on breath

    3. Look for common chief complaints

      a. Insomnia

      b. Nervousness

      c. "Flu" symptoms

      d. Gastric distress

      e. Trauma

      f. Seeking justification for sick leave

  B. Past health history

    1. Health-care-seeking behavior

      a. Uses multiple health care providers

        (1) fears being identified as alcoholic

        (2) has been refused health care

        (3) is seeking other addicting drugs

      b. Delays in seeking treatment for trauma

c. Fails to comply with treatment for chronic illness

d. Responds poorly to treatment regimen

2. Problems with health

a. May have negative history during early stage

b. May have multiple hospitalizations in late stage, including surgeries, arrhythmia, hypertension, trauma, seizures, pancreatitis, hepatitis, unexplained bleeding, history of alcohol treatment

3. Review of systems

a. May show clustering of symptoms in systems most affected by alcohol

b. Will show varying symptoms depending on chronicity of alcoholism

c. May have symptom clustering as follows:

(1) gastrointestinal: pain, nausea, vomiting, diarrhea, nutritional deficiencies

(2) neurological: insomnia, blackouts, seizures, tremors, headaches, withdrawal symptoms, peripheral neuropathy

(3) musculoskeletal: frequent trauma, fractures, bruises, night cramps, edema

(4) cardiovascular: hypertension

(5) respiratory: chronic infections

(6) genitourinary: men—impotence, infections; women—menstrual problems, infections, pregnancy problems

(7) skin: poor healing, infections, jaundice, vascular congestion

(8) psychiatric symptoms: nervousness, anxiety, depression, hallucinations, paranoia, suicide attempts or ideation

d. Requires direct query regarding past suicide attempts and present suicide potential as essential question during assessment

4. Family history

a. Reports alcoholism in parents or other family members

b. Reports depression in female relatives

c. States family or cultural drinking norms

5. Personal profile

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        - a. Family relationships
            - (1) problems: separation, divorce, children with behavior problems
            - (2) support system: strengths, weaknesses
        - b. Job status: demotion, firings
        - c. Law involvement: driving while intoxicated (DWIs) incidents, accidents, arrests
        - d. Hobbies, recreation in past and present
        - e. Health habits, including exercise, nutrition

IV. Pertinent Clues in Objective Data (T. Clark 1979; W.D. Clark 1980; Estes et al. 1980; Morse and Hurt 1979)

- A. Special considerations
    - 1. Physical examination must be adapted to condition of client because intoxication or withdrawal confuses the picture
    - 2. Clinical manifestations depend on chronicity of alcohol abuse
        - a. Early manifestations are subtle, often missed
        - b. Late manifestations offer dramatic symptomatology
- B. Examination
    - 1. General survey
        - a. Assess general appearance, unique characteristics, state of health, functional disabilities
            - (1) client may appear older than stated age
            - (2) muscle wasting may occur in late stages
        - b. Check vital signs, height, weight as baseline data
        - c. Expect that findings may be nonspecific
    - 2. Skin
        - a. Signs of trauma
            - (1) bruises at coffee or dining table height
            - (2) cigarette burns on fingers, chest, legs

        - (3) scars
        - (4) abrasions
    - b. Changes secondary to liver disease
        - (1) grey to yellow pigmentation
        - (2) spider angiomas
        - (3) palmar erythema
        - (4) scratch marks secondary to pruritus
        - (5) jaundice
    - c. Changes secondary to poor nutritional status, leukopenia, altered circulation, poor hygiene
        - (1) infected wounds
        - (2) evidence of poor healing
        - (3) ulcerations
        - (4) acne rosacea
    - d. Platelet deficiency: ecchymosis, hematomas
    - e. Changes secondary to cardiomyopathy
        - (1) nail clubbing
        - (2) cyanosis

3. Head and face: evidence of trauma; orbital fractures, subdural hematoma
4. Eyes
    - a. Periorbital edema
    - b. Scleral icterus
    - c. Conjunctival infection
    - d. Impaired eye movements, nystagmus
    - e. Unequal, sluggish pupils
    - f. Decreased visual acuity
5. Ears

   a. Infection, trauma
   b. Poor hearing
   c. Blood, cerebrospinal fluid in canal

6. Nose
   a. Deviated, perforated septum
   b. Cerebrospinal fluid
   c. Increased size and vascularity

7. Mouth and neck
   a. Caries, periodontal disease
   b. Purple, cyanosed tongue
   c. Jaundice of hard palate
   d. Cheliosis, smooth red tongue
   e. Leukoplakia, ulcerations, tumors
   f. Adenopathy

8. Chest and back
   a. Emphysematous changes
   b. Pain with palpation: muscle chest wall syndrome, fractured ribs
   c. Signs of acute infection

9. Breasts: gynecomastia

10. Heart, blood vessels
   a. Tachycardia
   b. Labile hypertension
   c. Cardiomegaly
   d. Jugular venous distention
   e. Signs of congestive heart failure (CHF)
   f. Arrhythmia
   g. Peripheral edema

11. Abdomen

    a. Ascites
    b. Dilated vessels around umbilicus
    c. Venous hum
    d. Splenomegaly
    e. Hepatomegaly
    f. Hemorrhoids
    g. Hematoemesis
    h. Melena, occult blood

12. Musculoskeletal

    a. Palpable muscle tenderness, pain
    b. Muscle weakness
    c. Muscle wasting
    d. Fractures

13. Genitourinary

    a. Testicular atrophy
    b. Infections

14. Neurological

    a. Mental status
        (1) alterations in consciousness
        (2) impaired thought processes
        (3) impaired orientation
        (4) concrete responses to questions
        (5) mood swings
    b. Motor function
        (1) ataxia
        (2) loss of coordination

        - (3) tremor
    - c. Cranial nerves: deficits in II, III, IV, VI
    - d. Sensory function
        - (1) peripheral neuropathy
        - (2) hearing deficit
    - e. Deep tendon reflexes
        - (1) hyperreflexic in withdrawal
        - (2) hyporeflexic in peripheral neuropathy, muscular myopathy

V. Laboratory Data (Estes et al. 1980; Morse and Hurt 1979; National Council on Alcoholism 1977)

- A. Tests selected: tests ordered will depend on index of suspicion and clinical findings
- B. Baseline complete blood count (CBC), urine, and liver function test (LFTs): these tests may be valuable
- C. Serum gamma-glutamyl transpeptidase (GGT)
    - 1. Researchers are exploring use of this test for diagnosis of alcoholism
    - 2. Elevation of this enzyme occurs in alcoholic persons with no other liver abnormality
        - a. Activity decreases in abstinence, rises during drinking
        - b. Phenobarbital, cholestasis also cause rise
    - 3. Research is not definitive, but findings can alert practitioner to alcoholism possibility

VI. Synthesis of Data for Diagnosis (Estes el al. 1980; Morse and Hurt 1979; National Council on Alcoholism 1977)

- A. Consider critical data areas (review clues in assessment)
- B. Use tool: "Criteria for the Diagnosis of Alcoholism" (Appendix D)
    - 1. Guide to significance of clues
        - a. Promotes early detection
        - b. Provides uniform detection

c. Identifies individuals at different levels of dependence

d. Identifies diagnostic levels on which to base treatment plan

2. Divisions of data

    a. Tracts: major and minor components

        (1) tract I: physiological, clinical

        (2) tract II: behavioral, psychological, attitudinal

    b. Manifestations

        (1) divided into early, middle, late stages

        (2) graded according to degree of implication of alcohol pathology

            (a) diagnostic level 1: classical

            (b) diagnostic level 2: probable

            (c) diagnostic level 3: potential

3. Diagnosis

    a. Positive diagnosis requires that one or more major criteria be satisfied and that several minor criteria in both tracts be present

    b. Assessment must fit a consistent whole to ensure diagnosis; isolated symptomatology is not adequate

    c. Psychiatric diagnostic workup may be necessary if primary diagnosis of alcoholism cannot be clearly established

VII. Approach to the Alcoholic Person and Family (Bissell 1980; Estes et al. 1980; Clark 1980)

A. Terminology

1. Know that the label "alcoholism" may be threatening

2. discuss the diagnosis in terms of presenting problem, physical findings, and concerns

3. Discuss alcohol as the basis of problems and the need for discontinuing use to resolve present and future problems

B. Statement of facts and findings: use direct, nonjudgmental, supportive approach

C. Reactions to diagnosis

1. Anticipate hostility, anger, denial

    2. Expect that feelings may be powerful

    3. Understand the reactions as part of illness pathology

    4. Deal with feelings in direct, supportive manner

D. Refusal to accept diagnosis, treatment

    1. Client has the right to own determination

    2. Nurse practitioner cannot force treatment

    3. Practitioner needs to give clear message of concern for client's welfare

    4. The door should be kept open for future contact: let the client know he/she should continue to seek health care with the nurse practitioner

    5. Family education about alcoholism should continue

    6. Family presence may be supportive, facilitative

    7. Nurse practitioner can form a strategy with family for initiating changes within family system

Teaching Methodologies

The material in this unit will require several teaching methods. Lecture and readings from the recommended background readings will enhance theory acquisition. Seminar sessions in which the students role-play interview techniques and examine screening tools and questionnaires will facilitate applying theory to real life situations. Students might videotape their role-playing sessions and critique the interactions. Much of this material will rely on clinical exposure to persons and families with alcoholism. Supervised clinical experience in a detoxification or alcohol rehabilitation center will be extremely valuable in assessment skill acquisition. Finally, design of a protocol by the student for clinical practice is an excellent learning tool and also may be used as an evaluative technique by the instructor. The protocol may address various aspects of assessment such as screening, withdrawal, and particular alcoholism consequences. Protocol examples are found in the references by T. Clark (1979) and by McElmeel and Di Denti (1980).

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Part Three: Management of Early and Chronic Alcoholism

Strategies Used in the Recovery Process

This unit examines the concept of mobilization as it applies to alcoholism management by the nurse practitioner. It considers strategies inherent in the nurse practitioner role that support a comprehensive, high-quality plan of care based on mutual participation and responsibility. The particulars of the nurse practitioner-client relationship, variables for matching clients and treatment methods, needs of special groups, and intervention levels are presented as essential considerations in designing such a plan of care. In addition, barriers to treatment are examined to assist the nurse practitioner in avoiding common pitfalls.

Learning Objectives

On completing this unit, the nurse practitioner will be able to

- Discuss alcoholism as an immobilizing illness
- Identify strategies that enhance mobilization of the alcoholic person toward recovery
- Identify pertinent variables to consider when choosing a treatment method for an alcoholic person
- Discuss special treatment needs of individuals in special groups
- Discuss the levels and degrees of intervention
- Identify barriers to treatment and successful recovery

Content Outline

I. Mobilization: Key to the Recovery Process (Lewis et al. 1981; Mitchell and Catanzaro 1980)

   A. Definition of mobilization: An energizing, supportive process that leads one to make full use of one's potential abilities

      1. Emphasizes mutual participation and responsibility

      2. Relies on the use of supportive strategies and resources

   B. Immobilization by alcoholism in all life areas

1. Physical
    a. Ill health
    b. Diminished energy
2. Psychological
    a. Defense mechanisms: denial, rationalization, projection
    b. Affective disturbances: depression, loneliness
    c. Thought disturbances
    d. Diminished emotional growth
3. Social
    a. Family, interpersonal relationship problems
    b. Increased isolation
        (1) old and new relationships are avoided
        (2) social outlet becomes the bottle
4. Cultural: alienation secondary to poor compliance with expectations of the culture
5. Economic
    a. Lack of money for necessities because of alcohol expenditures
    b. Job demotion or loss
6. Spiritual
    a. Blocking of spiritual paths by guilt and shame
    b. Failure to participate in spiritual experiences, engendering further alienation

C. Suitability of nurse practitioner role to mobilization process

1. Nurse practitioner skills are attuned to management of alcoholism
    a. Illness/wellness care
        (1) lifestyle assessment
        (2) strategy skills
    b. Alcoholism knowledge and skills

2. Outpatient clinical setting is appropriate for management of alcoholic persons
    a. Provides a pivotal point from which to coordinate care
    b. Makes ongoing health care possible
    c. Is accessible to family members so that
        (1) family health needs can be assessed and managed
        (2) the family can provide integral supports in the recovery process

II. Strategy Skills (Lewis et al. 1981)

A. Coordination

1. Recovery is a complex and lengthy process
    a. Requires multidisciplinary approach that could include physician, nurse practitioner, nurse, social worker, and other primary care providers
    b. Requires careful, continued coordination by one team member
    c. Requires coordinated efforts, since treatment failure is often attributed to lack of service coordination

2. Nurse practitioner can participate fully in coordination role
    a. Needs knowledge of and skills in alcoholism
    b. Knows management strategy skills
    c. Practices in outpatient setting
    d. Possesses collaborative skills, resource knowledge
    e. Participates in ongoing health care
    f. Has access to family members for education and support

B. Counseling

1. Strategy skills are crucial in mobilizing behavior change, problem solving, and lifestyle management

2. Nurse practitioner with appropriate training may conduct or fully participate in
    a. Individual counseling
    b. Family counseling
    c. Group counseling

3. Nurse practitioner without expertise will
   a. Need to understand the value and process of counseling
   b. Need to be able to identify, coordinate, and evaluate available resources
   c. Need to consider methods to gain such expertise

C. Education

1. Nurse practitioner needs to assist staff in understanding alcoholism, including drinking behavior and problems, myths, attitudes, consequences, intervention, prevention
2. Vital elements in strategy for all client contacts will include
   a. Procedures for alcoholism prevention, recognition, and intervention
   b. Information and education as integral components of clinic system
   c. Preparation in alcohol education and positive attitude formation for all clinic personnel who have contact with clients

D. Therapeutics

1. Nonpharmacological intervention strategies include
   a. Stress management skills, exercise programs, relaxation techniques within province of nurse practitioner
   b. Access to resources for biofeedback, autogenics, and meditation
2. Pharmacological intervention strategies include
   a. Prescription of medication, which
      (1) will depend on prescriptive authority and/or protocols
      (2) will be needed if drugs are used in withdrawal
      (3) may include disulfiram therapy
   b. Knowledge of medications, which
      (1) will involve monitoring the safe use of medications in individual clients
      (2) will need to include teaching clients about medication
      (3) will include preventing or intervening in polydrug misuses

E. Evaluation

1. Continuing evaluation is needed

        - a. To ensure quality care
        - b. To anticipate problems and intervene early
        - c. To use as a basis for treatment changes
    - 2. Evaluation plan is needed
        - a. To address individual needs
        - b. To include ideas from other disciplines on a regular basis

III. Factors Influencing Recovery

- A. Engagement process (Estes et al. 1980; Lewis et al. 1981)
    - 1. Entry into treatment
        - a. Early intervention prevents irreversible physical, psychological, and social consequences
        - b. Intact life motivates recovery
    - 2. Nurse practitioner-client relationship
        - a. Relationship must be satisfactory for positive treatment outcome
        - b. Nurse practitioner should be direct, supportive, nonjudgmental, knowledgeable
        - c. Mutual participation and responsibility are needed
            - (1) alcoholic person is responsible for drinking behavior, treatment, compliance, appointments
            - (2) nurse practitioner is responsible for carrying out treatment strategies with a holistic focus
            - (3) a nurse practitioner-client contract (with copies for both parties) clarifies responsibilities, facilitates ongoing care, and contains
                - (a) mutually determined and agreed on stipulations
                - (b) flexible provisions that are able to change over time
    - 3. Support system
        - a. Ideally, the family should be engaged in care
            - (1) the alcoholic person needs to be considered within the context of family, including
                - (a) how the family influences the alcoholic person

            - (b) how family members are influenced by the alcoholic person
            - (c) how recovery affects the family system
        - (2) if there is no intact family, other support systems must be generated, requiring
            - (a) assessment of possible resources
            - (b) development of other resources, such as friends, self-help groups
    - b. The family is a vital factor in successful rehabilitation
- 4. Individualized care
    - a. Careful assessment is needed of client's traits, beliefs, values, relationships, lifestyle, life situations, styles of coping
    - b. Understanding of the client aids in treatment decision
    - c. Specific areas of concern regarding client's alcohol involvement include
        - (1) extent and nature of involvement
        - (2) effect of alcoholism on general functioning: physical, psychological, social
        - (3) determination of client's greatest problem, which may be underlying psychiatric illness, serious medical problems requiring treatment, or alcoholism
        - (4) treatment history, which should cover the client's attempts on his or her own to solve alcohol problems: successes and failures
        - (5) personal perception of alcohol problem
        - (6) family perception of alcohol problem
        - (7) financial resources

B. Motivation (Estes et al. 1980; NIAAA 1978; Schuckit 1979)

- 1. Factors contributing to motivation
    - a. Crisis situations (divorce, job loss, health problem, legal problems) often coerce alcoholic persons into treatment decisions
    - b. A prolonged drinking bout can force abstinence because client is
        - (1) physically unable to tolerate more alcohol
        - (2) painfully aware of physical, psychosocial deterioration

        - c. Hospitalization for detoxification separates the client and alcohol
        - d. Presence of a knowledgeable, concerned support system helps because concerned others
            - (1) may be attuned to motivational factors for the alcoholic person
            - (2) may be able to use confrontation to enable a treatment decision
            - (3) can have knowledge of resources
    - 2. Factors blocking motivation
        - a. After passage of a crisis, drinking may resume
        - b. Alcoholic person may fail to see the role of alcohol in problems
        - c. Support system may be poor
    - 3. Nurse practitioner role in motivation
        - a. Nurse practitioner must be attuned to motivational situations to
            - (1) use crisis events to focus on alcoholism problem and treatment decision
            - (2) confront person in serious, supportive, nonjudgmental manner
            - (3) ensure the availability of resources
            - (4) focus on early involvement of significant others
        - b. Nurse practitioner must be aware of factors that block motivation to
            - (1) recognize subtle shifts in behavior that indicate client ambivalence about continuing treatment after a crisis has passed
            - (2) help the client understand the role of alcohol in his or her problems, using education and introduction of the client to a recovering alcoholic person

- C. Understanding the problems of the alcoholic person (Estes and Heinemann 1977; Heinemann and Smith-DiJulio 1977)
    - 1. Physiological disturbances
        - a. Toxic effects of alcohol are both direct and indirect
        - b. For full consideration of this problem, see the topic "Biophysical Consequences of Alcohol Use and Alcoholism" in Part One of this guide and the unit "The Diagnostic Process" in Part Two
    - 2. Hopelessness

a. Continued failure to control alcohol and its consequences generates feelings of hopelessness

b. Low expectation of future success is pervasive, immobilizing, and accompanied by feelings of powerlessness

c. Hopelessness may lead to depression and suicide attempts

d. Hopefulness needs to be engendered for successful recovery to occur

    (1) nurse practitioner needs to understand the nature of hopelessness as it affects each client; this involves

        (a) learning distinctive, contributory experiences

        (b) identifying obstructed goals

        (c) assessing nature of obstacles

        (d) assessing values, resources, and previous coping mechanisms

    (2) nurse practitioner will find the nature and degree of client's hopelessness difficult to validate, because

        (a) direct questions rarely elicit valuable information

        (b) behaviors, actions, emotional displays, and subjective feeling descriptions provide more valid clues than questioning

e. Treatment considerations

    (1) recovery is influenced by the degree of hopelessness the client feels concerning possible goal achievement

        (a) to maintain hope, goals should be formulated that require less achievement

        (b) expectations and performance will be externally influenced by significant others

            (i) if others communicate expectation of achievement, hope can be generated

            (ii) hope can be generated through various modes

                — clients can observe one another's differences and similarities

                — clients can form interacting social groups

        (c) hopeless persons often seek out hopeful people

- (i) nurse practitioner must have hope, be optimistic about recovery
- (ii) this hope and optimism must be communicated to the client

(d) plan for client should involve incremental increase of responsibility

- (i) high but realistic expectations are needed
- (ii) action-oriented behaviors can be measured
- (iii) hopefulness will be generated by success

3. Poor self-concept

a. Self-concept is described as the feeling state generated by one's beliefs concerning personal control or lack of control over events

b. Poor self-concept is closely linked with hopelessness; low self-worth is engendered when continued failure predominates

c. With a poor self-concept, the self is viewed as a failure and as unworthy, unacceptable

d. Others' perceptions of self influence self-esteem

- (1) alcoholism is stigmatized in this society
- (2) rejection becomes internalized to cause feelings of worthlessness

e. Poor self-concept creates blocks in emotional growth experiences

f. Enhancement of the client's self-worth is needed for recovery

- (1) client's view of self needs to be assessed
    - (a) limited information can be acquired from direct observation, since the alcoholic client
        - (i) conceals real feelings
        - (ii) uses grandiose, minimizing behaviors
    - (b) self-rejecting verbal and nonverbal behaviors can provide more valid indicators of self-concept than direct observation
- (2) poor self-concept will impede treatment

g. Treatment considerations

- (1) the clients' self-esteem can be enhanced by increasing their sense of competence through such means as

        - (a) helping them successfully meet realistic goals
        - (b) generating hope for their future
    - (2) clients need to be alerted to situations that may precipitate a drinking episode
        - (a) help is needed in recognizing high-risk situations and identifying alternative responses
        - (b) role-playing situations will assist the client
            - (i) practice of new behavior increases confidence
            - (ii) mastery leads to increased self-esteem
    - (3) clients need to learn how to set realistic goals
    - (4) clients need assistance in self-appraisal to
        - (a) recognize their assets
        - (b) accept the self as worthy
    - (5) nurse practitioners can influence clients' self-perception by
        - (a) verbalizing specific qualities of clients
        - (b) giving feedback on their contributions to recovery, which will increase self-awareness and enhance hope and self-worth

4. Social isolation
    - a. Satisfaction of basic needs depends on relationships with others (love, security, belonging)
    - b. Relationships and social skills often have been lost by the alcoholic person
    - c. Social isolation from important relationships results from the following causative factors:
        - (1) inconsistent, unpredictable behaviors lead to rejection by others and eventual destruction of relationships
        - (2) the alcoholic person's inability to carry out activities and respond to demands of daily living leads to problems
        - (3) family and friends' demands for abstinence cause further retreat
        - (4) the alcoholic person's intense loneliness and isolation generate further alcohol use as an antidote

d. The resocialization process requires an assessment of present and past supports

e. Treatment considerations

(1) evaluation of support system

(a) if the client's current supports encourage drinking, the support people's attitudes will need to be changed

(b) if the family is intact and concerned, family ties will need to be strengthened

(c) if client has no family, concerned friends must be used

(d) if client has no supports, help can be given in developing a source such as Alcoholics Anonymous

(2) training in social skills: clients may need to be taught social skills to facilitate their acquisition of a support system

IV. Formulating a Treatment Plan

A. Intervention considerations

1. Recovery (Estes and Heinemann 1977; Heinemann and Smith-DiJulio 1977)

a. Recovery is a difficult, complex process

(1) treatment deals with physiological and psychological disturbances

(2) client often needs to change lifestyle

b. Success depends on abstinence

(1) achieving abstinence is a formidable task considering the alcoholic person's dependence on alcohol

(2) the idea of life without alcohol is frightening for the alcoholic client

c. Rehabilitation aims to

(1) halt the illness process

(2) mobilize to the highest level of health possible

2. Treatment goals (Clark 1980)

a. First treatment goal is acceptance of alcoholism diagnosis by alcoholic person

(1) acceptance of illness is a difficult goal to accomplish and is hindered by denial, low self-concept, hopelessness, isolation, stigmatization

(2) if acceptance occurs, this will engender a change in perspective and can be considered a reversal of denial

(3) recovery rarely occurs without acceptance of illness

b. Second treatment goal is abstinence from alcohol

(1) initial period of abstinence following intoxication is referred to as detoxification

(a) produces withdrawal symptoms in physically dependent client

(b) allows nurse practitioner to cut through alcohol effects to person beneath

(c) the recovery plan is based on the client's ability to cope with life without alcohol as an antidote

(2) client's response: the alcoholic client reacts to the idea of abstinence by

(a) feeling extremely threatened by the idea of life without alcohol

(b) fearing withdrawal symptoms

(c) becoming ambivalent when considering consequences of life without drinking

(d) considering withdrawal to be an insurmountable task

(3) nurse practitioner's response: the caregiver needs to provide strong supports and to emphasize one day at a time in setting goals

B. Considerations in matching clients to treatment (Shulman and O'Connor 1980)

1. Variables in matching: the matching process requires coordination of many variables, and must take into account the varied clinical spectrum seen in alcoholism, the great diversity of treatment approaches, and a wide range of individual factors

2. Client variables and treatment choice

a. Biophysical and psychological factors to consider in the treatment choice include coexisting medical problems, coexisting psychiatric problems, and degree of structure required by client (see outline below)

b. Family, social, and other factors to consider in the treatment choice include the current living and employment situation; previous attempts at treatment; availability of time for treatment; consequences of relapse; patterns of substance abuse; age of client; physical handicaps; and sociocultural, economic, and intellectual-educational factors (see outline below)

3. Coexisting medical problems; treatment considerations

   a. Coexisting medical problems require a rehabilitation setting able to give proper care, since it would be counterproductive to interrupt alcoholism treatment for medical management elsewhere

   b. Appropriate settings would be residential treatment centers in acute care hospitals or freestanding treatment centers with associated medical care units

4. Coexisting psychiatric problems: treatment considerations

   a. Psychosis

      (1) clients with suspected psychosis need careful validation of the diagnosis with the client in a drug- and alcohol-free condition, along with psychological testing

      (2) psychotic clients may require antipsychotic drug therapy

      (3) the nurse practitioner should seek consultation or referral

      (4) appropriate treatment settings include

         (a) supportive environment

         (b) an alcoholism unit in or as an adjunct to a psychiatric hospital, so that ongoing psychiatric care can be provided

   b. Depression

      (1) diagnosis: the nurse practitioner needs to review the stages of depression and intervention; careful evaluation will be required to determine whether the depression is primary or secondary, with the client in an alcohol-free state for at least 6 months

      (2) treatment during interim before diagnosis: for mild to moderate depression, the nurse practitioner needs to

         (a) assess the client's suicide potential

         (b) offer support, reassurance

         (c) avoid antidepressant drug therapy until diagnosis is definitive

      (3) diagnosis and treatment of serious depression

(a) symptomatology includes significant sleep disturbances, high levels of agitation, suicidal ideation or threats, history of manic episodes, family history of affective disorders, somatic or other delusions

(b) prompt intervention is required

(c) immediate consultation or referral should be arranged

c. Character disorder: a long-term, highly structured, confrontational treatment program is required

d. Manifestations of immaturity, dependency require

(1) a long-term, highly structured program

(2) a gradual, controlled confrontation

e. Chronic brain syndrome: a long-term, highly structured, very supportive program is required

5. Degree of structure required: treatment considerations

a. A highly structured treatment program is recommended for clients with

(1) poor impulse control

(2) moderate degree of organic impairment

(3) need for help with socialization or resocialization skills (especially applies to younger clients)

(4) immature, dependent personalities

(5) previous history of unsuccessful treatment

b. More structured programs are usually long term to provide adequate time for behavior change

6. Current living situation: treatment considerations

a. Supportive environment: when family, friends, and job are intact, short-term, outpatient treatment may be feasible

b. Environment with poor supports or client with other drug addiction problems

(1) these problems will thwart rehabilitation goals

(2) clients need to be separated from their old environment

(3) clients need time to develop adequate support system

(4) an appropriate setting for treatment is a long-term inpatient facility and a halfway house afterwards

7. Employment situation: treatment considerations

   a. Nurse practitioner needs to evaluate client's job in terms of whether it may promote drinking during rehabilitation

   b. Inpatient care will probably be required for those in some occupations, such as

      (1) alcohol-related jobs (bartenders)

      (2) rotating shift work if the client is unable to arrange rehabilitation time

      (3) jobs with travel, since drinking may be promoted by isolation and loneliness, and travel may put constraints on treatment time

      (4) freelance work that is unstructured and isolating in nature

8. Attempts at previous treatment: treatment considerations

   a. The nurse practitioner should evaluate unsuccessful previous treatment attempts to

      (1) avoid the same type of program

      (2) avoid the same treatment setting

      (3) distinguish between general hospital admissions for medical treatment of alcohol sequelae and alcohol treatment programs

         (a) hospital admissions for medical treatment are not considered failures in treatment for alcoholism

         (b) the number of admissions and problems with alcohol treatment programs should be elicited

   b. The nurse practitioner should be familiar with available long-term programs that are designed specifically for persons with a history of treatment failures

9. Time availability: treatment considerations

   a. Time should be an important but not pivotal factor in selecting treatment options

      (1) alcoholic clients may use the time factor as an excuse to avoid treatment

      (2) the nurse practitioner needs to make a contract with the client that spells out the following:

    - (a) the client may continue in outpatient treatment if he or she remains abstinent
    - (b) the responsibility for avoiding inpatient care rests with the client
  - (3) some clients will need to make time for treatment
- b. Inpatient programs may create major problems for clients, e.g., single parents without child care support

10. Consequences of relapse: treatment considerations
    - a. Relapse can bring disastrous consequences in certain situations, including
      - (1) severe medical problems, e.g., varices
      - (2) probation
      - (3) termination of employment
      - (4) breakup of family
    - b. Potential consequences of relapse need to be carefully considered when choosing the appropriate treatment mode for each client

11. Patterns of substance abuse: treatment considerations
    - a. Concomitant drug abuse or involvement in a barroom subculture situation constitutes high-risk patterns of substance abuse
    - b. Clients reporting these patterns will require separation from their high-risk environments

12. Age of client: treatment considerations
    - a. Age of the client is a highly significant factor in choosing a treatment setting
    - b. Age of onset of drinking is also significant in choice of therapy because
      - (1) younger age of onset generally requires learning life tasks that were missed during the drinking career
      - (2) older age of onset generally requires a return to a previously successful lifestyle, with recovery meaning a return to the earlier level of successful functioning rather than the learning of coping mechanisms for the first time

13. Sociocultural, economic factors: treatment considerations
    - a. Incongruity between the caregiver's values and the client's can exist, leading to "culture shock" for the client

b. The client's feeling like a misfit will detract from treatment and he or she will not identify with other patients

c. Facilities having a broad cultural/socioeconomic base may mitigate the problem of differing values

d. Careful assessment of cultural problems and language barriers is needed by both the institution and the individual nurse practitioner

14. Intellectual-educational factors: treatment considerations

a. Clients with impaired intellectual ability will

(1) need long-term, highly structured, relatively simple programs

(2) be helped by reality therapy

(3) not benefit from analytical programs

b. Persons who have average intelligence but are illiterate need programs geared to their situation

c. Intellectual, well-educated clients benefit from programs with emphasis on analysis and insight

15. Physical handicaps: treatment considerations

a. Severe handicaps restrict the variety of programs available

b. Choice of an inpatient setting should follow a determination of whether the handicap will impede treatment

c. Choice of an outpatient setting should follow consideration of problems with travel and access

C. Considerations in meeting needs for special groups (Estes et al. 1980; Shulman and O'Connor 1980)

1. Alcoholic women

a. Treatment methods for women are needed that provide new ways to cope and give life new direction, including

(1) assertiveness training

(2) parenting skills

(3) self-confidence about femininity

(4) cultivation of vocational talents

- b. Alcoholic women, more than men, may need management of depression and polydrug use
- c. Women can benefit from interactions with other women in developing positive self-concept and coping skills
- d. Alcoholic women are likely to need assistance in acquiring adequate child care during the treatment period

2. Adolescents
   - a. Treating teenage alcohol abusers requires a staff and therapist with expertise in adolescent psychology and skills in dealing with personality problems beyond alcohol problems
   - b. Teenage polydrug users require a comprehensive program of accelerated treatment
   - c. Adolescent alcohol abusers require education about alcohol and alcoholism, as well as counseling that allows an opportunity to explore alternative ways of coping
3. Elderly
   - a. Treatment needs
     - (1) elderly alcoholics often require a longer term, more structured program than younger clients
     - (2) the elderly require more time to recover from the physical effects of alcohol
     - (3) the environment—housing, money, activities—must be manipulated to mitigate deprivation
     - (4) a social support system is vital to treatment success
     - (5) focus must be on improvement of general health
   - b. Onset considerations
     - (1) prognosis for those with early onset alcoholism is often poor
       - (a) attention should be paid to medical problems
       - (b) intervention will be needed in dysfunctional life areas
     - (2) prognosis for those with late onset alcoholism is good
       - (a) alcoholic persons whose problems began late in adult life are the most likely to benefit from social and interpersonal interaction

(b) Late-onset alcoholic elderly persons are more likely to remain in and benefit from treatment than early-onset clients

4. Blacks (Harper 1979)

a. Limitations of knowledge base

(1) few studies reported in literature

(2) most existing studies do not reflect cross-section of black population but focus on subsets (e.g., prison inmates, low-income communities)

b. Social, cultural, and personality factors that may influence treatment

(1) lack of access to services for low-income blacks

(2) failure to view excessive drinking as a problem requiring professional help if serious economic or legal problems exist

(3) tendency among rural black families to treat or deal with alcoholic family members at home

(4) language usage

(5) negative and discriminating attitudes by treatment personnel

(6) suspicious reaction by black alcoholics to white counselors or traditional programs

(7) characteristics of helping person that will facilitate or hinder treatment

(8) motivation of client may be higher in black alcoholic voluntarily entering treatment than in white counterpart

(9) degree of racial and economic oppression may be reflected in alcoholism rate within a black community

(10) high availability of alcohol in many black residential communities when compared to traditionally white residential communities

c. Emerging research findings regarding treatment of black alcoholics

(1) outreach counseling to encourage entry into treatment has been successful in black populations

(2) comprehensive outpatient services as opposed to drug therapy/psychotherapy may be more effective with black clients

(3) Alcoholics Anonymous (AA) should be considered as a treatment component, but sensitivity to cultural/racial differences must be maintained

(4) the black family and community (particularly the church) should be integral element of treatment

(5) treatment for physiological illness related to alcoholism should be similar for black and white alcoholics

5. Hispanics

a. Treatment considerations

(1) degree of acculturation to Anglo society affects treatment planning

(a) low degree of acculturation: clients should not be placed in treatment with a different identity group, because there is potential for detrimental "culture shock"

(b) high degree of acculturation: clients may blame alcohol on social stress and may need to overcome feelings of anger and bitterness before treatment can have a positive outcome

(2) machismo attitudes require careful consideration because the alcoholic male will be deterred from treatment if he is unable to admit alcohol problems

b. Family members

(1) the family can be key to treatment success, but family members may resist acting against the wishes of the male head of household

(2) the nurse practitioner needs to support the involvement of family members

c. Eradicating social stressors often mitigates alcohol problems for the Hispanic person

6. Native Americans

a. Treatment considerations

(1) group membership is essential to positive outcomes

(a) record of Alcoholics Anonymous (AA) in assisting recovery of alcoholic Native Americans is mixed

(i) AA has traditionally been unsuccessful

(ii) traditional AA groups lack Indian role models

(iii) a value conflict divides AA and Indian cultures

(iv) an alternative AA structure has been developed that conforms to Indian cultural values and encourages positive outcomes for Native Americans

(b) Native American Church provides support

(i) the church strongly supports abstinence

(ii) church membership offers an alternative way of life

(2) a support network is necessary

(a) Indians on reservations have access to tribal support systems, including the extended family

(b) Indians in urban areas lack a support system and require suitable alcoholism services

b. Strengths inherent in the Native American culture include strong family and/or tribal ties that can be used to enhance treatment

7. Asian Americans

a. Asian Americans have some tendency to use traditional health healers

b. Often members of this group do not seek help until a high degree of physical deterioration has occurred

c. It is essential for nurse practitioners to establish a relationship with the client and family by

(1) showing genuine interest

(2) being available to the family

(3) using informal means to make contacts when appropriate

D. Referral considerations (NIAAA 1978)

1. Agency information needed before making referrals

a. From the agency's perspective, information to be gathered about its clients includes

([illegible] characteristics of clients most successfully treated in agency's program (age, race, sex)

(2) most appropriate types of referrals to their agency

(3) types of clients who drop out of their program

(4) types of clients referred from their agency to other programs and reasons for referral

(5) nature of treatment goals

b. Information to be gathered about the agency's services includes

(1) availability of services for the entire family, for non-English-speaking persons, and persons with physical handicaps

(2) types, number, and education of staff

(3) program length, cost, third-party reimbursement, and provisions for medical costs

(4) types of therapy offered, including individual, family, and group counseling; educational programs; and adjunct vocational rehabilitation

2. Levels of professional intervention

a. Lowest level of intervention available involves providing information on accessible community resources, such as

(1) whom to contact

(2) address and directions for reaching resources

(3) specific program information (goals, clientele, costs)

b. Moderate degree of intervention is used when initial attempts to mobilize the alcoholic fail and involves

(1) evaluating reasons for previous failure

(2) arranging for someone to accompany the person to a community resource, such as an AA member, outreach worker, or friend

(3) having a resource come to the client on an outreach basis, such as AA, Al-Anon, Alateen, or agencies that serve such special groups as the elderly, blacks, Hispanics, and Native Americans

c. Intermediate degree of intervention is used when previous levels have failed and involves

(1) changing the focus to another family member, especially someone who has the interest and potential to grow and change

(2) organizing a structured confrontation

d. Highest degree of intervention involves taking legal means to seek the alcoholic person's commitment to a treatment program and includes

(1) providing the external motivation needed to mobilize a person when self-motivation does not occur

(2) making use of coercion with discretion, caution, and awareness of current State laws

3. Barriers to referral and treatment

a. The nurse practitioner may fail to recognize alcoholism as a disease

b. A failure in communication can happen with alcoholic persons

  (1) communication can be destroyed by labeling the person "alcoholic"

  (2) more positive results can be obtained by helping the alcoholic person make his or her own definition

c. Others may sabotage treatment efforts

  (1) family and friends may fail to support the treatment decision

  (2) health providers who lack alcoholism knowledge may thwart plans

d. Goals of client and nurse practitioner may be incongruent or inappropriate

  (1) the nurse practitioner may fail to establish mutual goals and to formulate a contract with the client

  (2) incongruent goals may result from differing social and cultural perspectives

    (a) ambiguities in societal attitudes toward drinking behavior

    (b) varying expectations of treatment outcome

  (3) chronic nature of disease and potential for relapse must be recognized

  (4) sobriety a reasonable long-term goal

e. The nurse practitioner may provide unrealistic information and foster undue optimism in the client

f. The nurse practitioner may fail to assess past attempts to get help

  (1) not understanding reasons for previous failure can set the client up to fail again

  (2) problems need to be evaluated to determine the best resources available at the present

g. Crisis intervention may provide relief that reduces client's efforts

  (1) the pain associated with alcoholism consequences is temporarily alleviated

  (2) the motivation to change is blunted

h. The nurse practitioner may be ignorant of proper referral sources

i. The nurse practitioner may attempt to handle the problem without help from other team members

j. Lack of thoroughness may subvert potential gains

    (1) referrals may fail to be followed up

    (2) the chance to intervene early before problems occur may be missed

k. Treatment alternatives may be lacking

    (1) various resources and some degree of flexibility are needed

    (2) present plans should be evaluated in light of possible need for other treatment methods

Teaching Methodologies

To begin the management phase of this course, the students should read I'll Quit Tomorrow (Johnson, 1973) and From the Family Trap to Family Freedom (Wegscheider 1981). The first class should focus on these readings and on the two films The Enablers and The Intervention (see Appendix B). Time for discussion will be needed to deal with the feelings generated by the readings and films. Lecture and discussion are appropriate teaching methods for the other content areas in this unit. The student should participate in management of the alcoholic person in a clinical setting. Student practice must be carefully supervised.

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The Process of Recovery and Specific Treatment Methods

This unit presents the phases of recovery, a process that consists of initial detoxification followed by long-term rehabilitation and aftercare. The long-term rehabilitation methods presented are those that have been identified as most acceptable and available.

The nurse practitioner must be able to identify existing resources within the community and be familiar with program approaches and contact personnel. Some communities have few resources and limited ability to provide comprehensive, individualized care. In this case, the nurse practitioner must take the initiative, making contact in nearby communities or initiating the development of new resources within the practitioner's own community.

Learning Objectives

On completing this unit, the nurse practitioner will be able to

- Identify the phases in the recovery process
- Discuss the common problems encountered by the alcoholic person in the recovery process
- Assess the events surrounding relapse and discuss intervention
- Discuss the value of specific treatment methods
- Identify counselor attributes and discuss the counseling process
- Develop a plan to enhance current, available resources
- Formulate a management plan for an alcoholic client

Content Outline

I. Detoxification (Estes et al. 1980; Shulman and O'Connor 1980)

  A. Detoxification process: a necessity for initiating rehabilitation

    1. A period of abstinence following a drinking bout is needed to remove alcohol from the body

    2. Clients' symptomatology during detoxification will be variable

  B. Detoxification models

    1. Medical model

      a. Detoxification occurs in hospital or other health care setting

      b. Care supervised by physicians and nurses

      c. Medications may be used to facilitate detoxification

      d. Complications of withdrawal and other health care problems may be managed

    2. Social model

      a. Based on philosophy of environmental manipulation, rather than medical treatment, in homelike setting

        - b. Supportive care provided by nonhospital personnel
        - c. Medications generally not used
        - d. Unsuitable for clients with conditions that may require skilled care
        - e. Safety depends on qualifications of staff to detect and refer clients with potentially dangerous conditions
    - 3. Self-management
        - a. Many alcoholic persons detoxify on their own without problems
        - b. Alcohol intake is gradually tapered
        - c. The withdrawal process may be painful and dangerous
- C. Goals during detoxification period
    - 1. A relationship of trust should be established between client and nurse practitioner
    - 2. A detailed history should be obtained
    - 3. Diagnosis should be established
    - 4. Short-term and possibly a definitive treatment plan should be developed
    - 5. Client should be introduced to others with whom identification is possible
    - 6. Safety of client should be assured
    - 7. Supportive environment should be maintained

II. Long-term Rehabilitation and Aftercare

- A. Process of recovery (Zuska and Pursch 1980)
    - 1. Process involving long, slow relearning
        - a. Alcohol has exacerbated underlying problems and inhibited positive coping styles
        - b. The process of recovery takes a minimum of 2 years
    - 2. Decisions about return to work following treatment
        - a. Ability of client to return to work needs careful evaluation
        - b. Type of work, degree of responsibility, supervisor's cooperation, severity and duration of illness, and progress made in early recovery need to be considered

c. Clients who participate in a sound treatment program at least two times a week may generally return to work after 4 to 6 weeks

d. Client may need to change to less stressful job

3. Physical and emotional health

a. Physical recovery usually proceeds rapidly in the first few months with recovery completed by year's end

b. Wide mood changes can be expected for clients in sobriety

c. Some clients experience (between 1 and 2 years) a rise above pretreatment levels in feelings of well-being and working ability

B. Crisis during recovery

1. High risk of crisis and relapse during first 2 weeks

a. Maintaining an open, concerned, supportive relationship with the client and family will be helpful

b. Both the client and family should be encouraged to seek out the nurse practitioner when a crisis occurs

2. Chronic, relapsing nature of disease

a. Psychiatric referrals based on crisis alone should be avoided

(1) usually only 2 to 5 percent of clients require psychiatric referral

(2) to be valid, a psychiatric referral usually should be made only after at least 6 months of sobriety

(3) if such a referral is made, the nurse practitioner should use a psychiatrist knowledgeable about alcoholism and AA

b. The nurse practitioner's efforts to enhance motivation need to continue through

(1) helping to set realistic hopes and short-term goals

(2) pointing out alternatives

(3) giving positive feedback for improvements

(4) allowing client participation and choice in treatment

c. Relapse considerations

(1) relapse is common

(a) vulnerability to relapse exists in the early weeks of recovery and during the 11th to 13th months

(b) course with resumption of drinking can vary

(i) renewed drinking does not necessarily proceed rapidly into dysfunctional behavior

(ii) eventually the signs and symptoms of medical and social problems emerge

(2) characteristic events that precede relapse include

(a) disappointment in sobriety

(b) emotional conflicts

(c) peer pressure for social drinking

(d) encouragement of drinking by significant person (enabler)

(e) excessive mood swings

(f) various life crises

(g) psychoactive medication prescription for disease

(h) overinvestment of self in attempts to rescue a new AA member

(3) the "building up to a drink" phenomenon can be combated

(a) this phenomenon begins with mood change anxiety, or psychosomatic complaint and culminates in a state of emotional irritability and confusion (dry drunk)

(b) this emotional state may precede the onset of drinking by days or weeks

(c) treatment will involve

(i) acceptance by the client of his or her vulnerable state

(ii) verbalization of feelings

(iii) planning of coping strategies

(iv) avoidance of drugs

(v) having a supportive nurse practitioner accessible

(vi) possible admission for inpatient treatment for a few days

(4) if drinking occurs the nurse practitioner needs to

- (a) confront the client
- (b) use the present crisis to motivate changes in behavior
- (c) point out alternatives
- (d) employ needed leverage to reinstate sobriety
  - (i) hospitalization can interrupt the drinking cycle
  - (ii) other persons, such as the employer, family, lawyer can be enlisted to urge sobriety

C. Common problems of alcoholic persons in sobriety

1. Honeymoon period
   - a. Initial positive reinforcement by significant others wanes (after 1 to 2 months)
   - b. The client's abstinence is taken for granted and expected to continue
   - c. The client experiences the decrease of overt reinforcement as a lack of support or as rejection
   - d. Return to the use of alcohol may ensue
   - e. Relapse may be avoided by the nurse practitioner through
     - (1) anticipatory guidance
     - (2) early recognition
     - (3) assisting the client in developing an internal versus external system of reinforcement
2. Problems with sexual dysfunction
   - a. With abstinence, the client should expect some sexual dysfunction in the early phase of sobriety
   - b. Clients need to be prepared for probable temporary dysfunction
     - (1) unprepared clients will think they are impotent or frigid
     - (2) clients are not likely to initiate the subject with the nurse practitioner
     - (3) the usual problem is diminished libidinal drive and depression
     - (4) the nurse practitioner needs to provide reassurance by talking with both partners when possible and suggesting that alternative methods for libidinal stimulation can be sought

3. Problems of trust versus mistrust

   a. The client seeks from others their complete trust that sobriety will continue

   b. A past history of broken promises will have engendered mistrust

      (1) significant others may view new behavior with doubt

      (2) some mistrust by significant others should be expected

   c. Client needs to be assisted in accepting a more realistic view of others' attitudes

      (1) the destructive behaviors and mistrust engendered in the past can be discussed

      (2) the focus can be on the client's accepting what trust is available and building from there

4. Problem of dysphoria associated with increased awareness

   a. Client believes abstinence should have eliminated anxiety, depression, and stress symptoms

   b. The client may, in fact, perceive symptoms more acutely without their chemical anesthesia

   c. Anticipatory guidance by the nurse practitioner will ease concern and frustration with the symptomatology

D. Evaluation of initial treatment plan (Estes et al. 1980; Clark 1980)

1. Basic principles

   a. Goal of abstinence is a means to an end, i.e., overall improvement of quality of life

   b. Recidivism or relapse reflects chronic nature of disease and does not necessarily mean treatment failure

2. Specific questions for evaluating improvement

   a. Does the client have a realistic understanding of alcoholism as it applies to his or her personal situation?

   b. Is the client actively participating in a treatment program?

   c. Is there improvement in family and social relationships?

   d. Is there job improvement?

   e. Is the client exhibiting longer periods of effective sobriety?

f. In case of relapse, are episodes of shorter duration and less destructive?

III. Specific Inpatient/Outpatient Treatment Modalities

A. Inpatient rehabilitation (Estes et al. 1980; Knott et al. 1980; Shulman and O'Connor 1980)

1. Types of programs

a. Short-term programs are

(1) 2 to 12 weeks (4 weeks most common) in duration

(2) more structured and more intense in level of treatment than longer term programs

(3) often limited just to initiating the ongoing recovery process

(4) likely to be covered by third-party reimbursement

b. Long-term programs are typically

(1) 3 months to 1 to 2 years in duration

(2) varied from high to low in amount of structure

(3) aimed at heavier emphasis on resocialization

(4) aimed at achieving more treatment goals within the duration of the program then shorter term rehabilitation

(5) somewhat different for traditional health care, with less medical, social service, and psychiatric expertise

(6) less likely than short-term programs to receive third-party reimbursement

c. Alcoholism rehabilitation centers are

(1) either specialized long- or short-term units

(2) varied in treatment delivery depending on the setting

(a) psychiatric hospitals have a psychiatric orientation to alcoholism

(b) the acute care hospital is more expensive but offers better third-party reimbursement

(c) a free-standing facility is less expensive, with less reimbursement

2. Short-term residential rehabilitation

a. Program content varies as to

    (1) existence of medical, social service, and psychiatric components

    (2) extent of AA involvement

    (3) degree of counseling sophistication

    (4) presence of vocational rehabilitation

b. Components common to most programs include

    (1) education on alcohol, alcoholism, AA programs, and problems of daily living

    (2) group therapy as a usual major treatment component, consisting of discussion groups and psychodynamically oriented groups

    (3) an individual counseling adjunct

    (4) in-depth psychological evaluation

    (5) development of a comprehensive medical and psychosocial treatment plan

    (6) provision of outreach services and outpatient care by the facility staff

c. Duration of short-term residential treatment entails

    (1) 4 weeks treatment as sufficient for most clients

    (2) a time element that most clients are able to comply with

        (a) clients can get short time away from family, job problems

        (b) no catastrophic life disruption occurs

d. Goals in short-term residential programs emphasize

    (1) that the program is only the beginning of recovery

    (2) that goals be realistic and involve

        (a) meaningful identification with the problem of alcoholism

        (b) realistic motivation for recovery

        (c) insight into the addictive process and consequences

        (d) a concrete plan for continuing recovery

3. Long-term residential rehabilitation

a. Long duration of treatment time is designed

(1) purposefully to disrupt the life situation to effect recovery

(2) to allow for a resocialization process

b. Components common to some facilities include

(1) low level of intensity

(2) forced separation from outside world, e.g.,

(a) telephone blackouts

(b) confinement to grounds

(c) restrictive visitation

(3) often rigid and autocratic environment with strongly confrontational therapy, although some programs are less autocratic, less confrontational, and designed to allow some outside contact

(4) progress measured by degree of responsibility client exhibits

4. Halfway houses

a. Structured transitional living situations in halfway houses are designed

(1) for the homeless or those from a dysfunctional home

(2) as a follow-up to short-term rehabilitation care

(3) to provide varying levels of intervention ranging from group living situations to settings almost comparable with inpatient situations

b. Components common to most facilities include

(1) sharing of house by 10 to 20 persons

(2) sharing of household responsibilities

(3) involvement in AA with AA meetings in the house

(4) period of stay lasting from 3 to 6 months to open-ended arrangements

5. Advantages of inpatient rehabilitation

a. A period of abstinence is guaranteed

b. Learning about illness proceeds rapidly

c. The client is impressed with the gravity of the situation

d. Inpatient status provides an opportunity to identify with and relate to other alcoholic persons

e. Health care delivery is more integrated than in outpatient setting

B. Outpatient rehabilitation

1. Outpatient alcoholism clinics

a. Organized treatment programs offered in outpatient clinics include

(1) postdetoxification

(2) postresidential rehabilitation (when continued structure is needed)

(3) halfway houses

b. Clinics may be connected with a larger mental health clinic or general hospital or may be freestanding

c. Outpatient clinics are treatment settings of choice when

(1) clients need structure

(2) AA participation alone is not adequate

(3) postresidential rehabilitation is needed

(4) clients are unable to get away for inpatient treatment

2. Rehabilitation through Alcoholics Anonymous (AA) (Bumbalo and Young 1973; Curlee 1974; Estes et al. 1980; Zuska and Pursch 1980)

a. History of movement

(1) AA was started in 1935 by two alcoholic men—Bill Wilson, stockbroker, and Bob Smith, physician, who

(a) were able to stay sober through their mutual support

(b) were peers sharing common experiences in alcoholism

(2) as part of their recovery, these men began working with other alcoholic persons who, in turn, worked with others

(3) gradually, small groups of sober alcoholic persons were meeting in cities across the United States

(4) AA has evolved into a highly successful, worldwide, self-help movement

b. Organization

    (1) the national level is governed by the General Service Board, made up of alcoholic and nonalcoholic members, who deal with business and finance

    (2) the local level is made up of individual groups

        (a) each group is self-supporting with voluntary personal contributions

        (b) meetings are held in public, rent-free places

        (c) no fees or dues are collected

        (d) meeting times are frequent, at any time of day

        (e) membership is open to all

        (f) some meetings are open to any interested person and others are closed, being limited to alcoholic persons only

c. Membership philosophy

    (1) only requirement of AA membership is that the person desires to stop drinking

    (2) the philosophy emphasizes personal action

    (3) The Twelve Steps embody the action philosophy and provide specific guidance on how to attain and maintain sobriety through

        (a) admitting powerlessness over alcohol

        (b) developing reliance on a power greater than self

        (c) practicing self-analysis, catharsis

        (d) providing restitution to people whom alcoholism has harmed

        (e) giving of self to other alcoholic persons without expectation of reward

    (4) Twelve Traditions: the organization's policy states that

        (a) each group is autonomous

        (b) groups are nonprofit in nature

        (c) groups cannot engage in controversy or express opinions on outside issues

        (d) anonymity is stressed, with principles being more important than personalities (no last names are used)

d. Therapeutics

(1) membership provides supportive fellowship based on mutual acceptance and support

(2) members participate by choice

(3) excellent role models are available, so members identify with people who have similar history and goals

(4) the therapeutic aim is to help oneself by helping others

e. Referral to AA

(1) the nurse practitioner should routinely discuss AA with the client

(2) referral should be personal versus general

(3) clients should be asked to refrain from judgment about the program until they have attended regularly for 3 months

(4) if the client becomes established in AA, be wary of declining attendance or other signs of avoiding AA

(5) AA does not damage alliance with the medical profession

(a) AA is an excellent resource for adjunctive therapy

(b) health providers should attend various meetings to gain familiarity with AA philosophy and individual groups

IV. Counseling Approaches: A Highly Valuable Adjunct to Other Treatment (Baker 1976; Weinberg 1973, 1977; Yalom 1974)

A. Group counseling

1. Peer group identity is vital to long-term management

a. Other persons can be seen at various stages of recovery

b. Homogeneity can be important for some individual race, gender, or cultural needs

2. Group work is valuable for dealing with anxiety, loneliness, isolation, anger, and inconsistent messages from others

3. Group participation occurs in a safe setting, using confrontation and role playing

4. An open-ended format with minimum structure is recommended

B. Individual counseling

1. Structure and purpose

    a. Individual counseling offers a positive interpersonal relationship to client in which sessions are

        (1) structured, constructive, and goal directed

        (2) focused on mutual participation and responsibility

        (3) varied in length according to need

    b. The goal of counseling is to enable a more positive, productive life through increased self-understanding and improved coping ability

    c. Counseling focuses on

        (1) current reality

        (2) active development of a working therapeutic relationship

        (3) manipulation of the environment

        (4) strengthening of ego assets

C. Counselor attributes (Baker 1976)

1. The counselor needs the ability to be direct, practical, positive, patient, realistic, optimistic, open-minded, empathic, and compassionate

2. The counselor needs knowledge of self and knowledge of alcoholism

D. Individual counseling phases: beginning phase of relationship

1. A data base about the client must be gathered for organizing therapy

    a. Information needed includes

        (1) the client's crisis management style as shown by previous coping abilities in both alcohol- and nonalcohol-related situations

        (2) the client's history

            (a) comprehensive, structured, factual information can ameliorate the valuation

            (b) explanations and judgments need to be avoided

    b. Others can be used to corroborate data

        (1) contacts should be made only with client's full knowledge

        (2) family, friends, and employer perceptions may be useful

c. Purpose of data base is to

(1) individualize treatment

(2) develop a treatment plan

(3) provide a basis for evaluation and measurement

(4) provide immediate feedback about alcohol-generated problems that the client is not aware of

d. Counseling techniques can help circumvent use of the client's defense system

(1) directness (asking specific, factual questions that require an informative response instead of a vague answer) and persistence are both important

(a) directness may alert defenses, so the client becomes evasive through storytelling, changing the subject, or minimizing events

(b) in the face of evasion, the counselor needs to keep repeating the question patiently

(2) alibis should never be discussed

(a) clients will attempt to rationalize their drinking

(b) the alibi system is nonproductive

(3) the counselor should expect hostility and anger

(a) hostile, angry feelings will emerge from anxiety-producing alcohol discussions

(b) these feelings may interfere with the counselor-client relationship or cause the client to terminate therapy

(4) intervention techniques will be needed to deal with hostility and anger

(a) the counselor can change the subject temporarily to a less threatening subject, which takes the heat off a sensitive area and is less overwhelming to the client

(b) the anger can be discussed directly

(i) the counselor needs to feel comfortable with this direct approach

— to be comfortable, the nurse practitioner needs to know his or her own feelings about anger

— if not comfortable, the counselor may express feelings of threat or retaliation toward the client

(ii) the direct approach may generate more anger

2. Expectations of therapy must be clarified
    - a. Client needs to express what he/she expects from therapy
    - b. Counselor needs to indicate own skills, methods, format
    - c. Mutual goals need to be established
        - (1) goals should be short-term, realistic
        - (2) a contract should be formed
    - d. Ground rules about alcohol need to be established
        - (1) abstinence needs to be maintained
        - (2) the difficulty of the task should be explained to the client and assistance provided in developing support system
        - (3) relapse after a period of abstinence needs to be handled constructively
            - (a) relapse can be used as a therapeutic opportunity to discuss factors surrounding use and to increase client's self-awareness
            - (b) intoxication at a therapy session can be handled by
                - (i) deciding the session will not take place because it likely will be unproductive
                - (ii) making arrangements to get the client safely home or to detoxification
                - (iii) using the event as a topic of discussion in the next session
        - (4) coming intoxicated to several sessions requires different options
            - (a) counseling may be temporarily discontinued
            - (b) other alternatives can be considered, e.g., inpatient treatment

E. Individual counseling phases: working phase of relationship

1. Alcohol and its effects need to be deglamorized
    - a. Client needs increased factual knowledge
        - (1) classes and literature can be recommended

    - (2) the counselor can help connect symptoms and consequences for the client with the facts about alcohol
    - (3) facts have a low potential for inducing anxiety

- b. Client needs to review drinking experiences and desires
    - (1) past drinking episodes and current day-to-day urges can be explored
    - (2) the counselor can encourage more accurate information about the meaning of drinking (this increases self-awareness)

- c. Client needs to develop techniques for accurate assessing of personal drinking through
    - (1) use of a diary
        - (a) past situations of intoxication can help identify situation pitfalls, useful for self-knowledge and future planning
        - (b) present urges can be examined to determine what actions the client took or could take next time to support sobriety
        - (c) the diary can be discussed fruitfully in therapy
            - (i) the diary provides an opportunity to give feedback on the outcome of certain feelings or behavior
            - (ii) feelings of the client can emerge
                - — initially, evaluation of events will be superficial
                - — when trust increases, deeper self-scrutiny and understanding of feelings behind the event will begin to emerge
            - (iii) the diary enables the counselor to focus on important issues, e.g.,
                - — needs related to drinking
                - — alternatives to drinking
                - — the client's strengths
    - (2) convening of a family conference
        - (a) the family can assist the client in defining more accurately why drinking occurs
        - (b) events and issues can be discussed with significant others to
            - (i) clarify perceptions

(ii) deal with problems previously not communicated

d. Client needs to develop foresight about drinking

(1) future implications of drinking should be discussed

(2) implications of drinking versus abstinence must be considered

(3) client needs to develop techniques for dealing with hypothetical drinking

(a) a list of pros and cons about drinking and not drinking can be developed

(i) the pro-con list is most productive later in therapy when the client has dealt with the consequences of alcohol

(ii) if done too early, the list may have more pros for drinking than cons, which reinforces drinking behavior

(b) the pro-con list can be expanded and discussed in therapy sessions

(c) the list is a useful tool for periodic review

(i) in abstinence, the list gives support

(ii) in relapse, the list may increase the inclination to return to therapy

e. Client needs expanded awareness about own potential with alcohol

(1) the counselor needs to reinforce the belief that

(a) the client is a worthwhile person

(b) the client is able to function without alcohol

(2) use of role playing in sessions can

(a) desensitize situations that are anxiety producing

(b) encourage helpful, positive, and appropriate responses through practice

2. Alternatives to drinking need to be discovered

a. Client often requires major lifestyle changes

b. Client needs to consider what will give life meaning, such as

(1) seeking a new consuming interest to replace alcohol (job, hobby, sport, friends, AA, religion)

(2) exploring, activating, and evaluating ideas

(3) looking at old facets of life still valid and workable

3. Serious life problems need to be worked on

a. Clients often feel overwhelmed with the enormity of problems

b. Problems need a resolution or more drinking will ensue

c. Techniques of support, reassurance, active assistance, and enhancement of problem solving will help the client

F. Individual counseling phases: termination phase of relationship

1. Termination is an important phase of therapy

a. Termination marks the point where the client takes charge of own life

(b) Learning that has taken place in therapy needs to be summarized

(c) The termination process usually takes two to three sessions to complete

(d) This is often a difficult phase for the client, who feels anger and fear at loss of the relationship

2. Certain counselor techniques can help facilitate the termination process

a. Counselor may request the client to write a summary of helpful and meaningful events related to therapy

b. Counselor can write a summary to give the client covering

(1) review of myths the client had about alcohol that served the client's drinking behaviors (in the client's words)

(2) progress of client during therapy

(a) positive progress toward life without alcohol can be delineated

(b) if no progress, whatever interfered can be indicated

(3) a specific prescription for action based on the client's learning or blocked learning, mentioning

(a) alternatives to drinking

(b) stress management skills

(c) danger signs

(4) summary of the client's strengths

3. Certain questions help establish whether the client is ready for termination (Estes et al. 1980)

    a. Has the client achieved significant progress toward goals?

    b. Can the client communicate nondefensively most of the time?

    c. Can the client handle the activities and demands of life without recourse to alcohol?

    d. To what extent is the client involved in a well-rounded life?

    e. Is the client making use of more internal resources, showing consistent, constructive involvement with work and meaningful interpersonal relationships?

    f. How is the client reacting to and handling problems?

G. Vocational rehabilitation (Knott et al. 1980)

1. Counseling may be needed for job instability, unemployment, and serious problems

    a. Client may lack job skills and potential

    b. Employment represents an area in which substantive changes in self-esteem may be needed

2. Program needs to focus on

    a. Evaluation of individual needs

    b. Personal adjustment

    c. Prevocational and vocational training

    d. Coordination, integration of rehabilitation services

    e. Job placement, case management, and followup

H. Employee alcoholism service

1. Employee assistance programs (EAPs) are supported by employers for alcoholic employees in many companies

2. Services offered include

    a. Training and consultation services for management and supervisory personnel

    - b. Screening, assessment, and problem-solving recommendations
    - c. Motivational counseling and referral services for alcoholic employees and family members
    - d. Followup services for employees involved in recovery
    - e. General education and information through programs and literature

V. Counseling Methods (Doherty 1974; Estes et al. 1980; Pelletier 1977; Steffen et al. 1977)

- A. Behavioral approaches
  - 1. Proponents of behavioral approaches believe alcoholism is learned behavior and that alcoholism therefore
    - a. Depends on both antecedent and consequent events
    - b. Can be modified or eliminated
    - c. Can be replaced by social learning techniques, which serve as alternatives to drinking
  - 2. Stress management approaches may be used to teach social learning techniques
    - a. Social and self-management skills may include
      - (1) vocational counseling
      - (2) marital, family counseling
      - (3) social skills counseling
    - b. Assertiveness training may
      - (1) counteract social pressures to drink
      - (2) allow effective communication of needs
      - (3) give an awareness of one's own rights as a person
      - (4) enhance self-concept and interpersonal relationships
    - c. Biofeedback may
      - (1) increase relaxation and desensitization to high-level anxiety
      - (2) raise awareness of personal power and self-management ability
    - d. Autogenics, meditation
      - (1) may teach relaxation, self-mastery techniques

        (2) are undergoing research to test effectiveness of these techniques with alcoholic persons

    e. Physical exercise may

        (1) improve general health state

        (2) decrease alcohol intake

B. Other therapies

1. Aversive conditioning

    a. Pairs unpleasant consequences with the desire to drink

    b. May be used in several modes, including emetic drugs, electric shock, or unpleasant imagery

2. Transactional analysis (Haykin 1977)

    a. Aims at a therapeutic goal to help the client give up scripted behavior (childlike) in favor of autonomous behavior (adult decisionmaking)

    b. Uses a group setting format

        (1) therapy requires 6 to 12 months of abstinence

        (2) client must contract to remain sober, avoid suicide, and not "go crazy"

        (3) client needs to realize therapy is for self and not for others

        (4) therapeutic style is supportive, confrontational

        (5) transactional analysis aids in establishing outside patterns of behavior that allow the client to meet basic needs and psychological hungers

    c. Depends on careful selection for client suitability

        (1) clients must be able to take care of self

        (2) clients must have ability to control behavior

3. Rational Emotive Therapy (RET) (Ellis 1974; Hindman 1976)

    a. RET deals with emotions and behavior, with emphasis on cognitive component

    b. Problems are believed to arise from

        (1) misperceptions

        (2) mistaken cognitions about what is perceived

(3) emotional underreaction

(4) emotional overreaction

(5) habitually dysfunctional behavior patterns

c. Emotional reactions are assumed to be caused by the client's conscious and unconscious philosophy, affecting his/her evaluations and interpretations

d. Sessions deal with specific, irrational ideas of the client, including

(1) discussing how ideas lead to emotional problems

(2) demonstrating how to challenge ideas

(3) encouraging elimination of irrational ideas and their replacement with rational hypotheses about self and the world

(4) discussing alternatives to those irrational ideas that are causing emotional disturbances for the client

e. Differences of RET from other therapies include

(1) deemphasis on early childhood and focus on present ability to make changes

(2) emphasis on deep philosophical change and scientific thinking

(3) use of psychological homework

(a) RET demands continual observation and questioning of client's own belief system

(b) homework assignments are made to practice changes

(c) RET helps the client accept self within the framework that no human should be condemned for anything

VI. Medication (Hindman 1976; Zuska and Pursch 1980)

A. Disulfiram (Antabuse)

1. Chemical action: barrier to impulsive drinking

a. Disulfiram interferes with aldehyde dehydrogenase

b. When combined with alcohol, the client experiences flushed face, sweating, palpitations, dyspnea, tachycardia, hypotension, nausea, vomiting

(1) intensity and duration of symptoms depend on

(a) the dose of Antabuse

        - (b) time interval since last dose
        - (c) amount of alcohol intake
        - (d) individual variation of response
    - (2) treatment considerations include
        - (a) expectation of a usually mild reaction that lasts about 30 minutes
        - (b) possible need for supportive therapy to restore blood pressure, control shock

2. Considerations in prescribing disulfiram
    - a. Disulfiram is especially useful for the first 1 to 2 years of sobriety
    - b. Client needs only to make the decision not to drink once a day versus several times a day without the medication
    - c. Drug should be administered only after full physical examination and is useful for
        - (1) patients willing to take it
        - (2) patients undergoing periods of stress
        - (3) patients with impulsive drinking patterns
        - (4) patients having repeated rehabilitation failures
        - (5) patients sentenced by law to rehabilitation
    - d. Side effects of the drug
        - (1) side effects include fatigue, somnolence, headache, dizziness, skin rash, gastrointestinal disturbances, peculiar taste and odor on breath (garlic-like)
        - (2) side effects disappear in 1 to 2 weeks
        - (3) side effects can be controlled by temporarily reducing dosage, then returning to prior levels
    - e. Contraindications include
        - (1) overt psychosis
        - (2) decompensating cardiac problems
        - (3) caution in patients taking isoniazid, coumadin, dilantin

        - (4) pregnancy

    3. Reasons for discontinuing therapy

        a. Medication may be discontinued based on patient's demonstrated ability to remain abstinent by

            - (1) actively participating in AA
            - (2) maintaining sobriety for 12 to 24 months

        b. Medication may be discontinued based on patient's improvement in emotional/personal growth areas, shown by

            - (1) coping with crisis without relapse
            - (2) improved family relationships
            - (3) disappearance of denial
            - (4) enhanced social ability
            - (5) growth in self-esteem

B. Psychoactive medications

1. Risk factor: psychoactive drugs create a brain state similar to the state created by alcohol and strongly awaken the desire for the drug of first choice—alcohol

2. High-risk drugs

    a. Tranquilizers, sedatives, opiates

        - (1) physicians may prescribe these drugs to reduce symptomatology without being aware of alcohol problems
        - (2) the drug effect can easily become a substitute for the effects previously obtained from alcohol
        - (3) the client is set up for rapid dependence by the cross-tolerance of alcohol and sedatives or minor tranquilizers

    b. Amphetamines: amphetamine use represents a chemical trap, because clients will attempt to combine them with alcohol or other sedatives

    c. Analgesics: often given for injury or trauma, analgesics enhance addiction possibilities

    d. Cough and cold preparations: some, including over-the-counter medicines, contain alcohol

3. Management

a. Caution should be exercised in prescribing these drugs

b. Client should be educated regarding risks of using these drugs

   (1) client should inform the physician, anesthesiologist, and other health providers of his/her alcoholism and possible adverse effects from use of these drugs

   (2) use of treatment methods other than medicine can be reinforced

VII. Aftercare (Estes et al. 1980; Zuska and Pursch 1980)

A. Aftercare is not a separate option, but a vital part of rehabilitation

B. Care can be provided in various ways

   1. Aftercare groups can be conducted at treatment centers

   2. Phone and letter contacts between the facility and client may be ongoing

   3. Aftercare groups can be set up in the client's home

   4. "Refresher courses" and postdischarge sessions can be provided

C. Most programs continue 3 months to 2 years after discharge

D. The nurse practitioner's role may include

   1. Provision of aftercare options

   2. Coordination, support, and evaluation of aftercare

Teaching Methodologies

Lecture, discussion, and seminar are appropriate techniques for teaching this unit. Practical application of the material is especially valuable for management planning and resource identification and evaluation. Each student should formulate a management plan for a newly diagnosed alcoholic client. This should be a written paper to be handed in for instructor evaluation and feedback.

A second project for the student is to assess alcoholism resources available in the community: identify the resources, evaluate their programs, and design a plan to enhance resource availability and comprehensiveness. This plan should be realistically creative. Consider the three levels of prevention, and include short-term and long-term goals. Students should present their written plan in seminar and hand it in for instructor feedback. In addition, students should attend AA meetings and present their reactions in seminar.

References and Recommended Background Readings

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The Family in Recovery

This unit focuses on family needs and problems during the recovery of the alcoholic family member. Typically, the family's extensive involvement with alcoholism has thwarted the needs and growth of individual members as well as the family as a whole. They are often unprepared to face the challenge of sobriety and develop their own potential. Unknowingly, they perpetuate old behavior patterns, continuing to engender an alcoholic milieu instead of enhancing recovery.

The family is instrumental in the rehabilitation of the alcoholic person and needs to be actively involved in the process. Education, anticipatory guidance, consideration and support of individual growth, and knowledge of and access to community resources are the methods by which positive involvement may take place. The nurse practitioner is able to engage in these management methods with the family and mobilize them toward a more successful outcome.

Learning Objectives

On completing this unit, the nurse practitioner will be able to

- Identify and evaluate family needs in recovery
- Formulate a plan for anticipatory guidance based on these needs
- Discuss the problems in sobriety
- Discuss and evaluate alcoholism resources for the family

Content Outline

I. Alcoholism as a Family Illness (Cork 1969; Estes et al. 1980; Wegscheider 1981)

   A. Family reactions to alcoholism

1. Families react in different degrees at different stages of the disease
2. Variables to consider in assessing the family state include
    a. Original health of the family
    b. Ages of various members
    c. Family's culturally determined attitude toward drinking
    d. Family's position in the community
    e. Degree of financial security

B. Alcoholism: cause of primary illness in each family member

1. Each part of the family system is affected
2. Each family member reacts and adapts to the surroundings
3. Family's goal is to decrease stress and maintain homeostasis
4. Pathology inhibits the development and satisfaction of family members' security, affection, and actualization needs

C. Common characteristics of family members

1. Characteristics are found in varying degrees depending on
    a. Personality of the family member
    b. Degree of disturbance within the family
    c. Level of earlier adjustment within the family
2. Behaviors found in family members include
    a. Inability to take appropriate responsibility in the family
    b. Lack of self-discipline
    c. Overdependence
    d. Preoccupation with self
    e. Negative attitude toward authority
    f. Sense of inadequacy
    g. Unrealistic, immature approach to living
    h. Limited interests, isolation

i. Shallow or superficial ways of relating to people

3. Survival roles (Wegscheider 1981)

   a. The chemically dependent person is typically characterized by the following:

      (1) behaviors: perfectionistic, grandiose, aggressive, righteous, charming, and blaming

      (2) self-worth: feelings of shame, inadequacy, and guilt

      (3) needs: confrontation, support, accountability, love, and acceptance

   b. The Chief Enabler, the family member who encourages the alcoholic person to continue destructive drinking, is typically characterized by the following:

      (1) difficulty in cooperating with treatment because recovery interferes with own needs

      (2) behaviors: super-responsible, martyred, fragile, sickly, powerless, complaining, and manipulative

      (3) emotions: feelings of anger and guilt

      (4) needs: support, self-care, confrontation, expression of feelings, and an improved self-image

   c. The Family Hero (usually a child), is typically characterized by the following:

      (1) behaviors: successful, performs well, independent, seeks approval, perceptive, and helpful

      (2) self-worth: feelings of guilt and inadequacy

      (3) needs: to allow for mistakes, to take risks, to experience vulnerability, and to express feelings

   d. The Scapegoat (usually a child), is typically characterized by the following:

      (1) sullenness, defiance, acting out behavior, chemical use, and blaming

      (2) self-worth: feelings of hurt at not being heard and loneliness

      (3) needs: support of feelings, confrontation, acceptance, challenge, and to be listened to

   e. The Lost Child is typically characterized by the following:

      (1) behaviors: creative loner, solitary, and withdrawn

      (2) self-worth: feelings of loneliness and rage

- (3) needs: invitation, consistency, encouragement, and rewards for efforts

f. The Mascot (usually a child) is typically characterized by the following:

- (1) behaviors: hyperactive, humorous, clumsy, and center of attention
- (2) self-worth: feelings of fear of not belonging and fear of breaking down
- (3) needs: physical touch, to be taken seriously, information, and to be asked for ideas

D. Individual member assessment and treatment (Estes et. al. 1980)

1. Each individual's need for care should be considered in his or her own right rather than considered merely as an adjunct to treatment of the alcoholic member
2. Each family member needs to deal with own conflicts, emotional upsets, and difficulties in relationships
   - a. Family members often develop reactions to alcoholism that create and perpetuate dysfunction
   - b. Growth that is delayed becomes dysfunctional living
   - c. Changes in individual members cause disequilibrium in the system and coerce changes in the alcoholic member
   - d. A treatment plan should be developed for each individual family member that addresses the need to
     - (1) learn about survival roles and try out new roles
     - (2) express and enhance self-worth
     - (3) learn to communicate feelings
     - (4) engage in healthy problem solving
     - (5) develop trust, acceptance, positive interpersonal relationships
     - (6) participate in ongoing care

E. Intervention considerations for the family (Clark 1980)

1. Family members may have difficulty accepting the diagnosis of alcoholism because of
   - a. Denial, fear, protection
   - b. Inability to accept abstinence or assistance
   - c. Need to be actively involved in the process

2. Family members may thwart or obstruct the recovery process because of their lack of support for recovery

3. Family members believe they are the cause of the alcoholism

    a. Even the children take on feelings of blame and guilt

    b. Reassurance and education of the family about the illness process and consequences will motivate a healthier perspective

    c. Family members need to examine their own behaviors because they

        (1) may have developed unhealthy behaviors in response to the alcoholic person and illness

        (2) must learn alternate responses that are positive and facilitative

4. Family members may have difficulty dealing with changes that occur during recovery

    a. New, positive changes in the behavior of the alcoholic person disrupt the previous homeostasis of the family system

    b. This turbulence and emotional turmoil can be frightening and overwhelming to family members

    c. The family needs anticipatory guidance and support through counseling and self-help groups

F. Specific problems in recovery (Estes and Hanson 1976; Estes et al. 1980)

1. Adjustment to sobriety is often difficult because this state is expected to be problem free

    a. Sobriety of the alcoholic spouse is a much anticipated happiness state

    b. Family members are often unprepared for the problems sobriety can bring

    c. The alcoholic person is often more difficult to live with than before abstinence began

    d. Old coping behaviors and unresolved family/marital problems emerge

    e. The family may remain dysfunctional, and relapse may ensue

2. Certain common problems are encountered by women with recovering spouses (Estes and Hanson 1976; Satir 1972)

    (Instructor should also cover the unique problems encountered when a different household member, such as the wife or a child is the recovering alcoholic)

    a. The husband wants to become reinstated into family roles

(1) the resumption of responsibilities as spouse and father

  (a) represents a difficult struggle fraught with discouragement and impatience

  (b) faces the pattern of years during which alcohol has created a dysfunctional unit and role reversal

(2) mutual trust needs to be reestablished, even though

  (a) trust has been destroyed by years of drinking

  (b) the wife is fearful of further disappointment, hurt

  (c) problems may exist with sexual dysfunction or a history of infidelity by the alcoholic partner

    (i) sexual problems may be difficult to deal with

    (ii) the spouse may fear resumption of infidelities with sobriety

    (iii) sexual difficulties may be particularly threatening because of a past history in which sex and alcohol were intertwined, e.g., sex may have been withheld from the alcoholic spouse to punish drinking

    (iv) past sexual difficulties may prevent the couple from engaging in sex through fear of jeopardizing sobriety

    (v) current sexual unresponsiveness of the recovering alcoholic may be felt by the wife as a threat to her femininity

  (d) responsibility needs to be relinquished or shared

    (i) the spouse may find it difficult to depend on the recovering family member who has a history of undependability

    (ii) the alcoholic member may react slowly to responsibility due to lack of self-confidence in abilities

  (e) the recovering alcoholic often may be absent from family life because of recovery activities

    (i) the spouse may feel resentment that the recovering partner is not at home

    (ii) the spouse who spends equal time in recovery activities for self may be more accepting of the alcoholic member's absence

b. Difficulties surround husband/wife communication

  (1) old communication patterns persist

(a) **rational communication was impossible with intoxication**

(b) **often silence alternates with explosiveness**

(c) **many issues of feeling are avoided**

(2) **universal communication patterns are used when the couple feel threatened (Satir 1972)**

(a) **double messages are common: what is said may be different from what is thought or felt**

(b) **universal communication patterns include the placater, blamer, computer, and distracter**

(i) **placater: feels helpless, worthless, and tries to hide feelings; behaves in an ingratiating manner, trying to please, and being apologetic to avoid angering others**

(ii) **blamer: feels worthless and tries to escape own feelings; acts superior, attempts to get others to obey, and makes others look worthless**

(iii) **computer: feels vulnerable and ignores own feelings; acts correctly, reasonably, and calmly in the face of threats; deals with facts**

(iv) **distracter: feels no one cares, that there's no place in life for self, and tries to avoid feelings; gives irrelevant answers that are rarely to the point, clouds real issues, and avoids seriousness**

(d) **communication behaviors need to be identified and confronted**

(e) **the couple can be taught to listen to one another with empathy, without prejudgment**

c. **Affective responses of the alcoholic person's wife are reminiscent of reactions during the drinking period and include**

(1) **fear of losing husband**

(a) **the wife feels incapable of managing the financial burden alone**

(b) **the wife wants to present a secure image to the outside world**

(2) **feelings of diminished self-worth, depression**

(a) **these feelings are related to despair about the relationship with the recovering alcoholic spouse**

(b) **a realistic acknowledgment of problems is needed**

- (i) problems can no longer be blamed on alcohol
- (ii) the wife must face the reactions of the recovering spouse

(c) the wife must learn to know the recovering spouse

- (i) the couple may never have known each other well
- (ii) the wife may have overestimated the abilities of the husband
- (iii) a more realistic appraisal is needed

(3) lingering resentments from unresolved anger

- (a) the wife has learned to close off her feelings, and to deny irritation and anger during drinking periods
- (b) the risk of confronting real feelings may be too threatening to undertake
- (c) past reaction patterns will tend to predominate, characterized by automatic responses from drinking days and irrational reactions to problems

d. The recovering husband may exhibit disruptive traits and behavior

(1) "dry drunk" syndrome is characterized by

- (a) the person's feeling uncomfortable when he is not drinking
- (b) a characteristic overreaction to problems
- (c) behavior becoming irrational
- (d) wife's returning to old reaction patterns in response to the syndrome

(2) other traits may be exhibited, such as evasiveness, egocentricity, moodiness, irresponsibility, oversensitiveness, and all-or-nothing thinking

e. Situations must be dealt with that involve alcohol and alcohol-related problems

(1) concern is likely to exist about maintaining sobriety

(2) difficulties can surround social situations related to alcohol

- (a) the alcoholic person may have sought support without admitting alcoholism as an illness

(b) social contacts may diminish to other recovering alcoholic persons only

(3) the wife may feel concern about how to respond to renewed drinking by the recovering alcoholic

II. Treatment Options for the Family Members

A. Self-help groups (Ablon 1974; Davis 1980; Estes et al. 1980)

1. Al-Anon

a. The group originated in the late 1940s and has been highly successful

b. Al-Anon focuses on special problems of spouse, relatives, and close friends of the alcoholic person

(1) principles are based on AA tenets

(2) treatment is geared to the individual in own right

c. The group process combines educational and operational principles

(1) members must accept and change their behavior

(2) the didactic lesson taught is that

(a) alcoholism is a disease

(b) alcoholism is not a moral condition

(c) acceptance of this concept leads to less shame, guilt, and anger of the family member or close friend

(3) operational principles taught are that

(a) the involved "other" needs to learn detachment from the alcoholic person

(i) it is not possible to control actions of another

(ii) members must change own behavior to make life better for themselves

(b) self-esteem and independence need to be reestablished

(i) self-improvement is a major goal

(ii) years of living with the alcoholic person diminishes these qualities

(c) the member needs to accept reliance on a higher power

- (i) strength for change is achieved through spiritual means
- (ii) the higher power can be religious or a religious personification, or can be a collective support group, depending on the member's own choice

d. Al-Anon provides a supportive peer group

- (1) mutual aid is provided for common problems, with a minimum of direct personal confrontation and much sharing of experiences, reactions, and practical strategies
- (2) members learn to change behaviors, and to gain new insights and introspection
- (3) members become involved in the recovery process to meet their own needs

2. Alateen

a. This youth organization is affiliated with AA

- (1) Alateen is geared to teenagers (Alatot is a similar group for younger children)
- (2) each group has an adult sponsor, usually an AA or Al-Anon member, who
  - (a) is responsible for developing and maintaining the group
  - (b) is present at meetings and available for help

b. Alateen focuses on the problems of children with an alcoholic parent, relative, or friend and teaches that

- (1) alcoholism is a family disease
- (2) persons are responsible for their own recovery
- (3) involved "others" need to concentrate on their own personal growth to mitigate the consequences of alcoholism in their lives

c. Alateen provides a supportive peer group

- (1) this sensitive environment promotes dialogue about problems associated with alcoholic parents
- (2) teenagers learn to rely on a higher power to
  - (a) help understand the alcoholic parent and his or her situation
  - (b) increase their personal sense of power

B. Counseling (Estes 1974)

1. Counseling the spouse of an alcoholic person: early phase

    a. The counselor needs to formulate a contract with the spouse covering

        (1) schedule, fee, appointment changes, and cancellations

        (2) treatment goals

        (3) counselor's approach to goal achievement

            (a) the counselor can help the spouse learn more about self

            (b) the approach to self-understanding may include

                (i) describing daily events in detail

                (ii) reviewing together examples of interactions

                (iii) learning more about thoughts, feelings, and actions

                (iv) exploring alternative behaviors

                (v) implementing alternative behaviors

            (c) increased self-understanding is the only specific outcome that the spouse can be promised

                (i) the spouse of an alcoholic often hopes for miracles

                (ii) the spouse needs to accept reality-based goals

    b. The counselor needs to help the spouse examine emotionally charged issues

        (1) an alcoholic's spouse is often burdened with sorrow, regret, confusion about life

        (2) spouse is prone to placing blame, finding fault, and making accusations

        (3) counselor helps the spouse relinquish these feelings

        (4) gradually the spouse will learn to value introspection regarding relationships

    c. The counselor needs to examine the spouse's experience with alcohol to clarify values, attitudes about alcohol

    d. The counselor needs to examine the history of the relationship with the marital partner, including

        (1) questions that elicit detail

(a) questions that concern the dating period, engagement, wedding, honeymoon, wedded period

(b) questions that provide insight into early problems

(2) an open discussion of the facts and feelings surrounding these events assist in honest consideration of the current relationship

e. The counselor needs to assist the spouse in realistic self-appraisal

(1) spouse of an alcoholic often has a negative, low self-concept

(2) questions can be asked in a way that elicits positive and realistic feelings of self-worth

(a) the spouse can describe and reexperience what she or he does well

(b) the quality of the counseling relationship is important

(i) the counseling relationship can be highly effective in building the spouse's healthy self-concept

(ii) the counselor must establish self as a person of significance to the spouse by competence, realness, and reliability

(iii) the spouse will develop a sense of personal worthiness as self-doubts diminish and as a new sense emerges of being an authentic person with real feelings, thoughts, and behaviors

f. The counselor needs to provide adequate factual knowledge about alcoholism

(1) information will help the spouse become an active part of the recovery process

(2) some facts about alcoholism may be difficult to accept

(a) the spouse will relive painful experiences

(b) the spouse must recognize and work through resistance with counseling

(3) with information, the spouse can directly apply facts to experience

(a) the spouse can understand defense mechanisms, domination, and withdrawal of the partner

(b) the spouse can begin to see actions as symptoms of an illness

(c) a less judgmental, more positive attitude toward change will emerge

- (4) the spouse needs knowledge about the physiological effects of alcohol
    - (a) the spouse will become aware of impaired judgment, inhibition, coordination, and concentration problems in the alcoholic partner
    - (b) the spouse will be more likely to consider safety factors in relation to the partner's intoxication

2. Counseling the spouse of an alcoholic person: middle phase

- a. The middle phase begins when the spouse can explore own problem areas openly and consistently as shown by
    - (1) looking more realistically at the marriage
    - (2) seeking less judgmental points of view
- b. The practitioner should examine the spouse's interaction pattern to
    - (1) identify and understand dynamics
    - (2) help the spouse understand he or she is not responsible for the alcoholic spouse's drinking problem
- c. The practitioner assists the spouse in developing more constructive coping styles
    - (1) coping styles used and reinforced during drinking periods are examined, including
        - (a) withdrawal within the marriage followed by protection, attack, safeguarding family interests, and acting out
        - (b) behaviors that have changed over time, depending on the state of drinking and on behaviors manifested by spouse or partner
    - (2) the spouse enters counseling immobilized by these coping styles
    - (3) the spouse needs help to gain insight into her or his behavior with others
        - (a) the spouse needs clearly to identify and acknowledge behaviors
        - (b) on-the-spot feedback can be provided on how the client's behavior affects the counselor
        - (c) the spouse is enabled to reexamine behaviors through open, honest discussion with the counselor
    - (4) the spouse can begin to change or mitigate responses
        - (a) specific responses can be identified

- (b) nonproductive and negative behaviors can be replaced with behaviors that are helpful and conducive to harmonious relationships
- (c) the long-term process requires practice
  - (i) deeply felt emotions will emerge
  - (ii) the client will begin to feel the full impact of life with an alcoholic partner
  - (iii) the spouse will begin to see that she or he too has an illness that
    - — parallels the partner's illness
    - — requires a healing process

3. Counseling the spouse of an alcoholic person: final phase
   - a. The final phase begins when the spouse actualizes self-worth by
     - (1) feeling more ego strength
     - (2) experiencing increased self-confidence and self-respect
     - (3) becoming capable of making good decisions
       - (a) decisions begin to be based on careful problem solving
       - (b) the spouse does not abandon the new skill when challenged
     - (4) the spouse appears physically rested, relaxed, and well groomed
   - b. The counselor can help the spouse deal with the partner's continued active drinking
     - (1) spouse will need guidance in formulating a plan to mobilize the partner into treatment
     - (2) a plan for confrontation needs to be developed, if appropriate, and if the alcoholic partner can psychologically cope with confrontation
       - (a) essential points of confrontation should be reviewed
       - (b) the confrontation can be practiced through role play
         - (i) the spouse needs to participate in both roles
         - (ii) role playing decreases stress of the actual event
       - (c) the spouse needs to prepare for the partner's probable responses

- (i) the partner will attempt to use defense mechanisms such as denial, rationalization, and projection
- (ii) the spouse can plan positive responses, including
  - — not arguing or debating
  - — standing firm that an alcoholic person cannot recover by continuing to drink
  - — allowing the partner to struggle with this by him- or herself (responsibility for drinking is the partner's)

(3) the counselor can assist if the alcoholic partner agrees to treatment

- (a) the couple can be put in immediate contact with resources
- (b) the spouse can be encouraged to allow the partner to take as much initiative as possible

(4) the counselor can assist the spouse if the alcoholic partner refuses treatment

- (a) the counselor may need to tell the spouse about the decision
- (b) refusal of treatment will require the spouse to make decisions about own future
- (c) counseling sessions can be used to review available alternatives
  - (i) separation or divorce may be considered
  - (ii) the spouse's decision needs to be based on the fact that the spouse cannot force the partner into treatment
  - (iii) once the spouse accepts this as the partner's decision, the spouse can give more consideration to own needs

4. Counseling the spouse of an alcoholic person: termination phase

- a. The termination phase can begin when the spouse has reached a point at which her or his confidence in personal abilities will sustain a course of action
- b. Termination evolves slowly over several sessions
  - (1) the process is complex
  - (2) ample time must be provided to work through feelings about separation from the counselor
- c. Counselor and client need to share perceptions about the counseling accomplishments

(1) both client and counselor can make a summary statement

(2) the growth achieved can be reviewed, along with areas of needed growth

5. Family counseling (Cork 1969; Davis 1980; Rogers 1970)

a. Family counseling approaches are valuable to the counselor because they provide

(1) more accurate diagnosis of the family

(2) a quicker, more effective means of resolving negative and self-perpetuating interactions

(3) deeper insights into the dynamics of family relationships

(4) an identification of the degree of health and pathology in each family member

b. Family counseling is also valuable for the family, because it provides

(1) a setting in which each member can safely share feelings, discuss behaviors, and react to others

(2) support and intervention from the counselor that prevents destructive retaliation from other members

(3) an opportunity for each family member honestly to face his or her own responsibility in the family disruption

(4) encouragement for discovering ways to establish healthier family life

c. Family counseling approaches alcoholism as an illness

(1) the family is treated as the primary medium in which change occurs

(2) counseling consistently focuses on all family members to include cross-generational relationships

(3) the family is treated as a supportive agent

(a) members identify behaviors and learn alternate behaviors requiring support

(b) the counselor facilitates acting out of family dynamics in therapy sessions

(c) under direct supervision, strategic interruption and intervention take place

(4) observation of relationships provides the potential for different ranges of problem solving

        - (a) direct observation allows the counselor to learn and guide the family along several dimensions
        - (b) the counselor can identify and substitute functions that serve alcoholic behavior
        - (c) the family can be guided through trial experiences with new and more satisfactory alternatives
    - (5) other family members are recognized as also suffering from alcohol-engendered problems

6. Other community resources (Estes et al. 1980) include
    - a. Parents Anonymous
    - b. Child protective services
    - c. Shelters for battered women

Teaching Methodologies

Lecture, discussion, and seminar formats are suited to the material in this unit. The students should, at this point, reconsider their management plans for the alcoholic person in terms of the family members and their needs. This should be written and handed in for instructor evaluation and feedback. In addition, the students should attend Al-Anon and Alateen meetings and present their reactions in seminar.

References and Recommended Background Readings

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Appendix A: Resources

Addiction Research Foundation
33 Russell Street
Toronto, Ontario M5S 2S1
(807) 595-6000

The Addiction Research Foundation offers for sale various educational materials, including pamphlets, fact sheets, books, and audiovisual products. Two periodicals are published: The Journal and Projection (film and video review service). An Educational Materials Catalogue can be obtained by writing to the foundation.

Center of Alcohol Studies
Research Information and Publications Division
Rutgers University
P.O. Box 969
Piscataway, NJ 08854
(201) 932-3510

The Research Information and Publications Division of the Center of Alcohol Studies is concerned with systemizing knowledge about human uses of alcohol. The division's specialists collect, classify, and abstract scientific literature on alcohol and alcoholism; this organized knowledge is available through the following publications and services. (Prepaid orders are shipped postage free.)

> The Journal of Studies on Alcohol - A primary source of new information on all aspects of alcohol and alcohol problems; published monthly; $35 annual subscription. To order, write: Journal of Alcohol Studies at the above address.
>
> Other Publications - The Publications Division also publishes and distributes a variety of books, monographs, and technical and nontechnical pamphlets and reprints. A catalog of publications is available on request.
>
> Bibliographies - A list of more than 500 bibliographies is available on request. All bibliographies are updated continually and are keyed to abstracts in the Rutgers Center collections. Photocopies of abstracts or full-text documents are also available. A fee of $2.50 covers photocopying costs.
>
> Information Services - The Center of Alcohol Studies library houses major collections of books, periodicals, dissertations, and other materials pertaining to alcohol studies. Full library services are available for use in person or by mail, including interlibrary loan and photo duplication of materials. For further information or to request services, contact Research Information Staff.

National Clearinghouse for Alcohol Information (NCALI)
P. O. Box 2345
Rockville, MD 20852
(301) 468-2600

The Clearinghouse is an information service of the National Institute on Alcohol Abuse and Alcoholism (NIAAA). Information is gathered from worldwide sources and disseminated to the field from this central point. The Clearinghouse offers the following products and services:

Information Requests

Responses and Referrals - Clearinghouse staff respond to individual inquiries of a personal, professional, or technical nature. They provide referrals to other agencies when appropriate.

Literature Searches - Clearinghouse specialists perform searches of computerized files containing citations and abstracts for scientific, technical, and programmatic documents in areas such as medicine, physiology, biochemistry, public health, psychology, animal research, treatment and therapies, mental health, legislation and criminal justice, safety, sociology, prevention and education, statistics, and special population groups.

Publications

The Clearinghouse distributes, free of charge, limited numbers of alcohol-related pamphlets, books, posters, and other materials published by NIAAA. These range from audiovisual information, to program idea books, to basic question-and-answer pamphlets, to reports to Congress summarizing the current scientific knowledge on alcoholism and alcohol abuse. Order forms and lists of materials are available.

Health Professions Education Project Package for Nurse Educators - This package contains a wide range of curriculum resources for the instructor in alcohol abuse.

Alcohol Topics in Brief - The Clearinghouse produces a series of fact sheets that offer concise information on subjects of high interest to the alcoholism community. Current topics include alcohol and youth, alcohol and women, and health insurance coverage for alcoholism.

Selected Translations of International Alcoholism Literature (STIALS) - The Clearinghouse translates and makes available important foreign language articles to researchers and other interested persons.

Subscription Services

The Clearinghouse offers two subscription services to keep professionals and nonprofessionals informed about the latest developments in alcoholism and alcohol abuse prevention, treatment, and research.

Alcohol Health and Research World (AH&RW) - The quarterly magazine of NIAAA has proven to be a reliable resource for those who want to keep abreast of current developments in the alcohol field. Regular features of the magazine include survey articles, new programmatic approaches, research findings, and in-depth reports on all aspects of alcohol, as well as book reviews.

The annual rate for Alcohol Health and Research World is $11.00 for domestic subscriptions ($13.75 foreign). To receive a 1-year subscription to World, send your remittance to:

Superintendent of Documents
U. S. Government Printing Office
Department 35
Washington, D. C. 20402

Alcohol Awareness Service - This service provides periodic, continuing notification of recent technical and scientific books, journal articles, conference proceedings, and programmatic materials. Alcohol Awareness registration forms are available from the Clearinghouse. A 1-year subscription costs $15.00.

All requests for information, publications, and subscriptions should be mailed to the Clearinghouse at the above address.

National Council on Alcoholism (NCA)
Publications Department
733 Third Ave.
New York, NY 10017
(212) 986-4433

NCA distributes a wide variety of publications on all aspects of alcohol use and abuse. For a full listing, write NCA for a Catalog of Publications.

Educational Materials Catalogues

Comp Care Publications
2415 Annapolis Lane
Suite 140
Minneapolis, Minnesota 55441

Hazelden Educational Services
Box 176
Center City, Minnesota 55012

Johnson Institute
Literature Department
10700 Olson Memorial Highway
Minneapolis, Minnesota 55441

U.S. Journal of Drug and Alcohol Dependence
2119 A Hollywood Boulevard
Hollywood, Florida 33020

Appendix B: Audiovisual Materials

Films (16mm; color)

A Slight Drinking Problem, 1977
25 min.; rent or purchase

Availability: Norm Southerly Productions
1709 E. 28th
Longbeach, CA 90806

Synopsis: The troubles that befall an alcoholic are exacerbated by his wife's reactions and attempts to deal with him. With the help of Al-Anon, she begins to cope with her own life.

Use: Excellent for demonstrating the value of self-help groups such as Al-Anon.

Francesca Baby, 1976
46 min.; rent or purchase

Availability: Walt Disney Educational Media
500 S. Buena Vista St.
Burbank, CA 91500

Synopsis: A mother's excessive drinking causes social and emotional problems for her daughters. The mother eventually goes to Alcoholics Anonymous. Based on a book of the same title.

Use: Although long, the film is good for demonstrating the predicament of teen children of alcoholics and the role Alateen can play in helping them resolve their problems.

Soft is the Heart of a Child, 1978
20 min.; rent or purchase

Availability: Operation Cork
P.O. Box 9550
San Diego, CA

Synopsis: Family violence, child abuse, and neglect are depicted in a believable setting. An alcoholic father convinces his wife to join him in drinking. The film illustrates such themes as the family consequences of drinking, community paralysis, women as battered spouses and drinkers, children as victims and emissaries to the community, the role of the school, and enabling.

Use: Demonstrates the effects of alcoholism on the family. Each of the three children respond almost predictably. Highly recommended for medical students.

The Enablers, 1978
23 min.; rent or purchase

Availability: The Johnson Institute
10700 Olson Memorial Highway
Minneapolis, MN 55441

Synopsis: The well-intentioned behavior of family, friends, and a supervisor helps an alcoholic mother-wife-employee-neighbor to continue her drinking. Each person close to the woman suffers yet seems unable to break out of a self-defeating pattern of interaction; each person is shown undermining the efforts of the other to gain control over the woman's problem. First of a two-part series with The Intervention.

The Intervention, 1978
28 min.; rent or purchase

Availability: The Johnson Institute
10700 Olson Memorial Highway
Minneapolis, MN 55441

Synopsis: Second in a series with The Enablers, the husband joins forces with the supervisor to gather together family and friends for coercive, constructive confrontation of an alcoholic wife-mother-employee-friend. The process of setting up such a confrontation is demonstrated, including the pitfalls to successful preparation.

Use: Excellent for supplementing The Enablers, for demonstrating enabling family dynamics, intervention, and teamwork. Also good for demonstrating how one can help the emissary from a troubled family motivate a chemically dependent person to seek treatment.

The Secret Love of Sandra Blain, 1976
27 min.; rent or purchase

Availability: Hollywood Enterprises
6060 Sunset Blvd.
Hollywood, CA 90028

Synopsis: The first in a three-part series, The Secret Love of Sandra Blain is the convincing story of a middle-class housewife whose hidden drinking becomes obvious to her family and friends. Denial by Sandra and her husband limits the effectiveness of therapy. Eventually the alcoholism becomes so severe that denial no longer helps Sandra deceive herself or those around her.

Use: An excellent introduction to alcoholism and the middle-class housewife. The film elucidates denial as one of the key factors in alcoholism.

The New Life of Sandra Blain, 1976
27 min.; rent or purchase

Availability: Norm Southerby Productions
1709 E. 28th
Longbeach, CA 90806

Synopsis: Because of Sandra's alcoholism, she is denied custody of her children. She begins to drink again. The frustration with drinking problems eventually turns Sandra back toward treatment. This film is the second in the Sandra Blain series.

Lisa: The Legacy of Sandra Blain, 1979
22 min.; rent or purchase

Availability: Aims Instructional Media
626 Justin Avenue
Glendale, CA 91201

Synopsis: Sandra Blain's daughter, Lisa, starts down the heavy drinking road following her mother's death. Lisa cannot be convinced she has a problem. Lisa is the third part of the Sandra Blain series.

Use: Shows that children who have one or more alcoholic parents are in a high-risk group. Emphasis is on identifying "the problem" in oneself.

Video Cassettes

Alcoholics Anonymous: An Inside View, 1979
28 min.; rent as 16mm or long-term lease as video cassette

Availability: Alcoholics Anonymous
Box 459
Grand Central Station
New York, NY 10163

Synopsis: This video cassette takes the viewer inside a variety of AA meetings, from the smallest, intimate, closed meetings to the large, open ones. It emphasizes the idea that AA is a way of life: any time two members get together there is an AA meeting.

Use: An excellent introduction to Alcoholics Anonymous; especially helpful for medical students prior to their visiting any AA meeting.

It All Adds Up, 1979
11 min.; rent or purchase

Availability: Marketing Department
Addiction Research Foundation
33 Russell Street
Toronto, Canada M5S 2S1
(416) 595-6056

Synopsis: This documentary video cassette explores the problem of alcohol consumption. Comparing countries, the narrators discuss the growth of alcohol use as well as different forms of legislation that have been introduced to regulate it.

Use: Very useful in pointing out international and legal issues surrounding alcohol consumption; not a key tape, however, if course time is limited.

Appendix C: Short Michigan Alcoholism Screening Test

1. Do you feel you are a normal drinker? (By normal we mean you drink less than or as much as most other people.) (No)*
2. Does your wife, husband, a parent, or other near relative ever worry or complain about your drinking? (Yes)
3. Do you ever feel guilty about your drinking? (Yes)
4. Do friends or relatives think you are a normal drinker? (No)
5. Are you able to stop drinking when you want to? (No)
6. Have you ever attended a meeting of Alcoholics Anonymous? (Yes)
7. Has drinking ever created problems between you and your wife, husband, a parent, or other near relative? (Yes)
8. Have you ever gotten in trouble at work because of drinking? (Yes)
9. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking? (Yes)
10. Have you ever gone to anyone for help about your drinking? (Yes)
11. Have you ever been in a hospital because of drinking? (Yes)
12. Have you ever been arrested for drunken driving, driving while intoxicated, or driving under the influence of alcoholic beverages? (Yes)
13. Have you ever been arrested, even for a few hours, because of other drunken behavior? (Yes)

Scoring: 0-1 point = nonalcoholic
2 points = possible alcoholic
3 points = alcoholic

A "yes" answer to questions 6, 10, or 11 is diagnostic of alcoholism.

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* Alcoholism is indicated by responses in parentheses.

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Appendix D: Criteria for the Diagnosis of Alcoholism

TABLE 1

Major Criteria for the Diagnosis of Alcoholism

CRITERION	DIAGNOSTIC LEVEL
TRACK I. PHYSIOLOGICAL AND CLINICAL	
A. Physiological Dependency	
1. Physiological dependence as manifested by evidence of a *withdrawal syndrome* when the intake of alcohol is interrupted or decreased without substitution of other sedation. It must be remembered that overuse of other sedative drugs can produce a similar withdrawal state, which should be differentiated from withdrawal from alcohol.	
a) Gross tremor (differentiated from other causes of tremor)	1
b) Hallucinosis (differentiated from schizophrenic hallucinations or other psychoses)	1
c) Withdrawal seizures (differentiated from epilepsy and other seizure disorders)	1
d) Delirium tremens. Usually starts between the first and third day after withdrawal and minimally includes tremors, disorientation, and hallucinations.	1
2. Evidence of *tolerance* to the effects of alcohol. (There may be a decrease in previously high levels of tolerance late in the course.) Although the degree of tolerance to alcohol in no way matches the degree of tolerance to other drugs, the behavioral effects of a given amount of alcohol vary greatly between alcoholic and nonalcoholic subjects.	
a) A blood alcohol level of more than 150 mg. without gross evidence of intoxication.	1
b) The consumption of one-fifth of a gallon of whiskey or an equivalent amount of wine or beer daily, for more than one day, by a 180-lb. individual.	1
3. Alcoholic "blackout" periods. (Differential diagnosis from purely psychological fugue states and psychomotor seizures.)	2
B. Clinical: Major Alcohol-Associated Illnesses. Alcoholism can be assumed to exist if major alcohol-associated illnesses develop in a person who drinks regularly. In such individuals, evidence of physiological and psychological dependence should be searched for.	
Fatty degeneration in absence of other known cause	2
Alcoholic hepatitis	1
Laennec's cirrhosis	2
Pancreatitis in the absence of cholelithiasis	2
Chronic gastritis	3
Hematological disorders:	
Anemia: hypochromic, normocytic, macrocytic, hemolytic with stomatocytosis, low folic acid	3
Clotting disorders: prothrombin elevation, thrombocytopenia	3
Wernicke-Korsakoff syndrome	2
Alcoholic cerebellar degeneration	1
Cerebral degeneration in absence of Alzheimer's disease or arteriosclerosis	2
Central pontine myelinolysis } diagnosis only possible postmortem	2
Marchiafava-Bignami's disease } diagnosis only possible postmortem	2
Peripheral neuropathy (see also beriberi)	2
Toxic amblyopia	3
Alcohol myopathy	2
Alcoholic cardiomyopathy	2
Beriberi	3
Pellagra	3
TRACK II. BEHAVIORAL, PSYCHOLOGICAL, AND ATTITUDINAL	
All chronic conditions of psychological dependence occur in dynamic equilibrium with intrapsychic and interpersonal consequences. In alcoholism, similarly, there are varied effects on character and family. Like other chronic relapsing diseases, alcoholism produces vocational, social, and physical impairments. Therefore, the implications of these disruptions must be evaluated and related to the individual and his pattern of alcoholism. The following behavior patterns show psychological dependence on alcohol in alcoholism:	
1. Drinking despite strong medical contraindication known to patient	1
2. Drinking despite strong, identified, social contraindication (job loss for intoxication, marriage disruption because of drinking, arrest for intoxication, driving while intoxicated)	1
3. Patient's subjective complaint of loss of control of alcohol consumption	2

Developed by the National Council on Alcoholism (NCA).

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TABLE 2

Minor Criteria for the Diagnosis of Alcoholism

CRITERION	DIAGNOSTIC LEVEL
TRACK I. PHYSIOLOGICAL AND CLINICAL	
A. Direct Effects (ascertained by examination)	
1. Early:	
Odor of alcohol on breath at time of medical appointment	2
2. Middle:	
Alcoholic facies	2
Vascular engorgement of face	2
Toxic amblyopia	3
Increased incidence of infections	3
Cardiac arrhythmias	3
Peripheral neuropathy (see also Major Criteria, Track I, B)	2
3. Late (see Major Criteria, Track I, B)	
B. Indirect Effects	
1. Early:	
Tachycardia	3
Flushed face	3
Nocturnal diaphoresis	3
2. Middle:	
Ecchymoses on lower extremities, arms, or chest	3
Cigarette or other burns on hands or chest	3
Hyperreflexia, or if drinking heavily, hyporeflexia (permanent hyporeflexia may be a residuum of alcoholic polyneuritis)	3
3. Late:	
Decreased tolerance	3
C. Laboratory Tests	
1. Major—Direct	
Blood alcohol level at any time of more than 300 mg./100 ml.	1
Level of more than 100 mg./100 ml. in routine examination	1
2. Major—Indirect	
Serum osmolality (reflects blood alcohol levels): every 22.4 increase over 200 mOsm/liter reflects 50 mg./100 ml. alcohol	2
3. Minor—Indirect	
Results of alcohol ingestion:	
Hypoglycemia	3
Hypochloremic alkalosis	3
Low magnesium level	2
Lactic acid elevation	3
Transient uric acid elevation	3
Potassium depletion	3
Indications of liver abnormality:	
SGPT elevation	2
SGOT elevation	3
BSP elevation	2
Bilirubin elevation	2
Urinary urobilinogen elevation	2
Serum A/G ration reversal	2
Blood and blood clotting:	
Anemia: hypochromic, normocytic, macrocytic, hemolytic with stomatocytosis, low folic acid	3
Clotting disorders: prothrombin elevation, thrombocytopenia	3
ECG abnormalities	
Cardiac arrhythmias; tachycardia; T waves dimpled, cloven, or spinous; atrial fibrillation; ventricular premature contractions; abnormal P waves	2
EEG abnormalities	
Decreased or increased REM sleep, depending on phase	3
Loss of delta sleep	3
Other reported findings	3
Decreased immune response	3
Decreased response to Synacthen test	3
Chromosomal damage from alcoholism	3

TABLE 2 cont.'d

Minor Criteria for the Diagnosis of Alcoholism

CRITERION	DIAGNOSTIC LEVEL
TRACK II. BEHAVIORAL, PSYCHOLOGICAL, AND ATTITUDINAL	
A. Behavioral	
1. Direct effects	
Early:	
Gulping drinks	3
Surreptitious drinking	2
Morning drinking (assess nature of peer group behavior)	2
Middle:	
Repeated conscious attempts at abstinence	2
Late:	
Blatant indiscriminate use of alcohol	1
Skid Row or equivalent social level	2
2. Indirect effects	
Early:	
Medical excuses from work for variety of reasons	2
Shifting from one alcoholic beverage to another	2
Preference for drinking companions, bars, and taverns	2
Loss of interest in activities not directly associated with drinking	2
Late:	
Chooses employment that facilitates drinking	3
Frequent automobile accidents	3
History of family members undergoing psychiatric treatment; school and behavioral problems in children	3
Frequent change of residence for poorly defined reasons	3
Anxiety-relieving mechanisms, such as telephone calls inappropriate in time, distance, person, or motive (telephonitis)	2
Outbursts of rage and suicidal gestures while drinking	2
B. Psychological and Attitudinal	
1. Direct effects	
Early:	
When talking freely, makes frequent reference to drinking alcohol, people being "bombed," "stoned," etc., or admits drinking more than peer group	2
Middle:	
Drinking to relieve anger, insomnia, fatigue, depression, social discomfort	2
Late:	
Psychological symptoms consistent with permanent organic brain syndrome (see also Major Criteria, Track I, B)	2
2. Indirect effects	
Early:	
Unexplained changes in family, social, and business relationships; complaints about wife, job, and friends	3
Spouse makes complaints about drinking behavior, reported by patient or spouse	2
Major family disruptions: separation, divorce, threats of divorce	3
Job loss (due to increasing interpersonal difficulties), frequent job changes, financial difficulties	3
Late:	
Overt expression of more regressive defense mechanisms: denial, projection, etc.	3
Resentment, jealousy, paranoid attitudes	3
Symptoms of depression: isolation, crying, suicidal preoccupation	3
Feelings that he is "losing his mind"	2

Developed by the National Council on Alcoholism (NCA).

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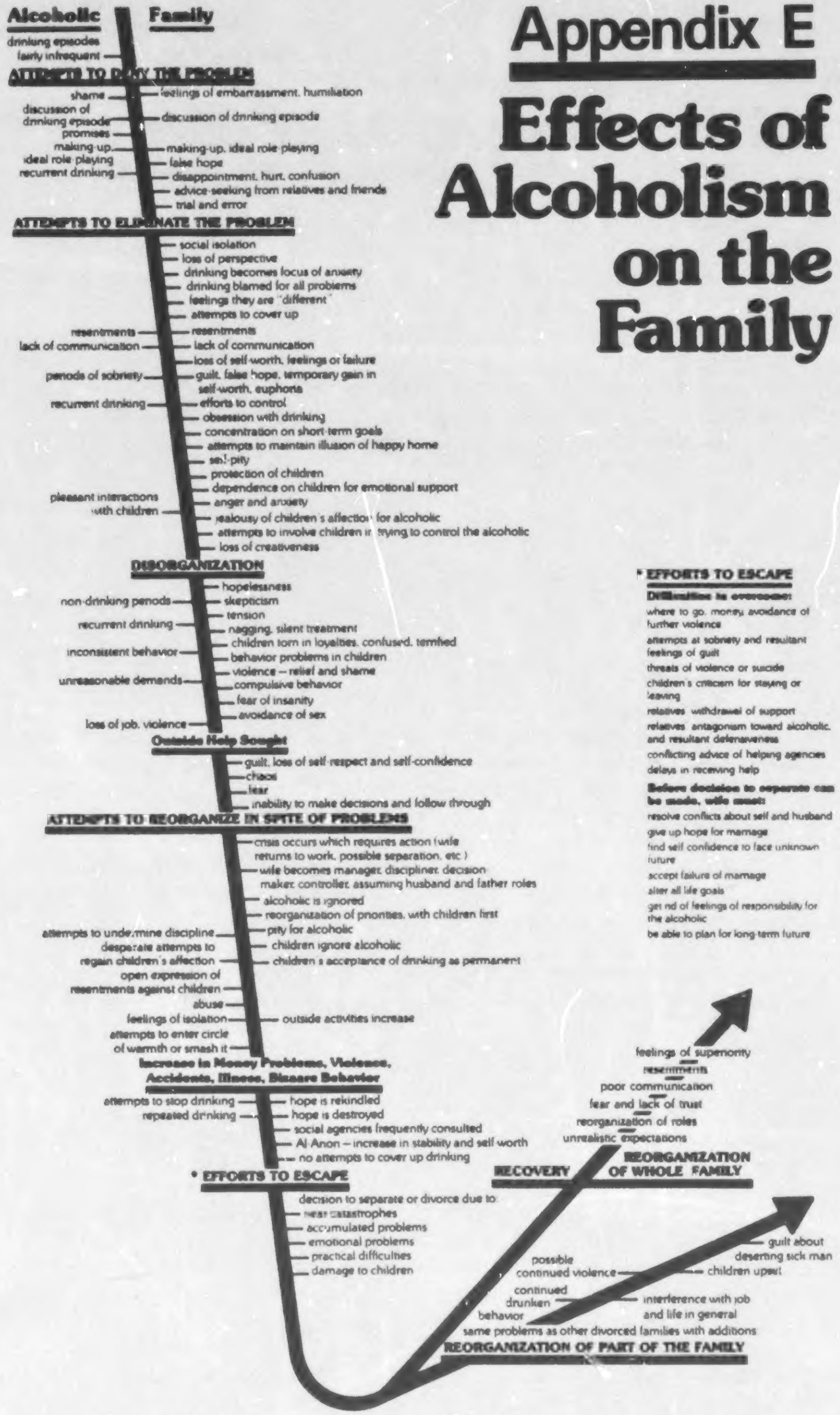
Appendix E

Effects of Alcoholism on the Family


Alcoholic
Family
drinking episodes fairly infrequent
ATTEMPTS TO DENY THE PROBLEM
shame
feelings of embarrassment, humiliation
discussion of drinking episode
discussion of drinking episode
promises
making-up, ideal role-playing
making-up, ideal role-playing
recurrent drinking
false hope
disappointment, hurt, confusion
advice-seeking from relatives and friends
trial and error
ATTEMPTS TO ELIMINATE THE PROBLEM
social isolation
loss of perspective
drinking becomes focus of anxiety
drinking blamed for all problems
feelings they are "different"
attempts to cover up
resentments
resentments
lack of communication
lack of communication
loss of self-worth, feelings of failure
periods of sobriety
guilt, false hope, temporary gain in self-worth, euphoria
recurrent drinking
efforts to control
obsession with drinking
concentration on short-term goals
attempts to maintain illusion of happy home
self-pity
protection of children
dependence on children for emotional support
pleasant interactions with children
anger and anxiety
jealousy of children's affection for alcoholic
attempts to involve children in trying to control the alcoholic
loss of creativeness
DISORGANIZATION
hopelessness
non-drinking periods
skepticism
tension
recurrent drinking
nagging, silent treatment
children torn in loyalties, confused, terrified
inconsistent behavior
behavior problems in children
violence – relief and shame
unreasonable demands
compulsive behavior
fear of insanity
avoidance of sex
loss of job, violence
Outside Help Sought
guilt, loss of self-respect and self-confidence
chaos
fear
inability to make decisions and follow through
ATTEMPTS TO REORGANIZE IN SPITE OF PROBLEMS
crisis occurs which requires action (wife returns to work, possible seperation, etc.)
wife becomes manager, discipliner, decision-maker, controller, assuming husband and father roles
alcoholic is ignored
reorganization of priorities, with children first
attempts to undermine discipline
pity for alcoholic
children ignore alcoholic
desperate attempts to regain children's affection
children's acceptance of drinking as permanent
open expression of resentments against children
abuse
feelings of isolation
outside activities increase
attempts to enter circle of warmth or smash it
Increase in Money Problems, Violence, Accidents, Illness, Bizarre Behavior
attempts to stop drinking
hope is rekindled
repeated drinking
hope is destroyed
social agencies frequently consulted
Al-Anon – increase in stability and self-worth
no attempts to cover up drinking
* EFFORTS TO ESCAPE
decision to separate or divorce due to
near catastrophes
accumulated problems
emotional problems
practical difficulties
damage to children
feelings of superiority
resentments
poor communication
fear and lack of trust
reorganization of roles
unrealistic expectations
RECOVERY
REORGANIZATION OF WHOLE FAMILY
guilt about deserting sick man
possible continued violence
children upset
continued drunken behavior
interference with job and life in general
same problems as other divorced families with additions
REORGANIZATION OF PART OF THE FAMILY

*** EFFORTS TO ESCAPE**

Difficulties to overcome:

where to go, money, avoidance of further violence

attempts at sobriety and resultant feelings of guilt

threats of violence or suicide

children's criticism for staying or leaving

relatives' withdrawal of support

relatives' antagonism toward alcoholic, and resultant defensiveness

conflicting advice of helping agencies

delays in receiving help

Before decision to separate can be made, wife must:

resolve conflicts about self and husband

give up hope for marriage

find self confidence to face unknown future

accept failure of marriage

alter all life goals

get rid of feelings of responsibility for the alcoholic

be able to plan for long-term future

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Appendix F: Nurses' Attitudes Toward Alcohol and Alcoholism

THE SEAMAN-MANNELLO SCALE
FORM B

There are 30 statements concerning alcohol and alcoholism. Please read each statement carefully and then decide how strongly you agree or disagree with each statement. Indicate your agreement or disagreement with each item by entering a number in the space provided according to the following scale.

1. STRONGLY DISAGREE
2. DISAGREE
3. NEITHER AGREE NOR DISAGREE
4. AGREE
5. STRONGLY AGREE

You may feel that a particular statement doesn't describe all alcoholic people. You may know an alcoholic person who isn't like other alcoholic people. Please answer the questions as they apply to most alcoholics or "alcoholic people in general." Also there may be some questions that ask about experiences you haven't had. If so, answer those questions with what you believe to be true. Please answer every question.

Please respond to each statement frankly. To receive the full benefit of your alcohol educational experience, you should strive to be as honest as possible in your responses to these items. Your responses will be personal and confidential.

Also, remember that there are no "right" or "wrong" answers. These statements are not designed to tell how good a nurse you are and no one will be judging you on the basis of your responses.

Source: National Institute on Alcohol Abuse and Alcoholism. The Community Health Nurse and Alcohol-Related Problems: Instructor's Curriculum Planning Guide. Arlington, VA: National Center for Alcohol Education, 1978. The Seaman-Mannello Scale, named for its designers, James Seaman and Timothy Mannello of University Research Corporation, was developed by the National Center for Alcohol Education for the National Institute on Alcohol Abuse and Alcoholism.

Indicate how much you agree or disagree with each of the following statements by entering a number on the line to the right of each statement according to the following scale:

1. STRONGLY DISAGREE
2. DISAGREE
3. NEITHER AGREE NOR DISAGREE
4. AGREE
5. STRONGLY AGREE

Please remember that it is important to respond to every statement.

---

1. The life of an alcoholic is not a very pleasant one. 1. ________
2. I feel I work best with alcoholic patients. 2. ________
3. Alcoholics are not just concerned with their own happiness. 3. ________
4. Alcoholics are very sensitive people. 4. ________
5. Alcohol in moderate amounts can actually be beneficial to a healthy person. 5. ________
6. Alcoholics are usually in poor physical health. 6. ________
7. I prefer to work with alcoholic rather than other patients. 7. ________
8. Alcoholics respect their families. 8. ________
9. The alcoholic suffers from feelings of inferiority. 9. ________
10. There is nothing wrong with drinking moderate amounts of alcohol. 10. ________
11. I think that it is unfortunate that alcoholics often suffer from the delirium tremens. 11. ________
12. Alcoholics deserve hospital space just like any other patient. 12. ________
13. Alcoholics want to stop drinking. 13. ________
14. Alcoholics were driven to drink by other problems. 14. ________
15. Alcoholic beverages are harmless when used in moderation. 15. ________
16. Alcoholic patients need psychiatric consultation. 16. ________

(continued)

17. I don't think that my patients would become angry if I discussed their excessive drinking with them. 17. ________

18. Alcoholics who do not obey the nurse's orders should be treated anyway. 18. ________

19. Alcoholics feel they are bad people because of their drinking. 19. ________

20. People should drink alcoholic beverages if they wish to. 20. ________

21. Alcoholics should receive medical treatment. 21. ________

22. I feel comfortable when working with alcoholics. 22. ________

23. Most alcoholics do not like being alcoholics. 23. ________

24. An alcoholic is lonely. 24. ________

25. When used wisely, alcoholic beverages are no more harmful to normal adults than nonalcoholic beverages. 25. ________

26. Alcoholism is an illness. 26. ________

27. It does not embarrass me to talk to alcoholics. 27. ________

28. I can help an alcoholic even if he or she will not stop drinking. 28. ________

29. Alcoholics usually have severe emotional difficulties. 29. ________

30. The consumption of alcoholic beverages cannot make normal people weak and silly. 30. ________

NURSES' ATTITUDES TOWARD ALCOHOL AND ALCOHOLISM

THE SEAMAN-MANNELLO SCALE
FORM B
SCORING SHEET

You are now ready to score your answers. There are five different things being measured by the questionnaire you have just completed. You will calculate your scores yourself. Your instructor will be glad to help you if you need assistance.

Step 1. Transfer your answers from your answer sheet to the appropriate spaces on this sheet.

1. ____________
6. ____________
11. ____________
16. ____________
21. ____________
26. ____________
Q. ____________

2. ____________
7. ____________
12. ____________
17. ____________
22. ____________
27. ____________
R. ____________

3. ____________
8. ____________
13. ____________
18. ____________
23. ____________
28. ____________
S. ____________

4. ____________
9. ____________
14. ____________
19. ____________
24. ____________
29. ____________
T. ____________

5. ____________
10. ____________
15. ____________
20. ____________
25. ____________
30. ____________
U. ____________

Step 2. Add up each column of numbers and enter the totals on the lettered spaces at the bottom of each column

You have now finished scoring your answers. Your instructor will tell you what each of these numbers means.

Instructor's Guide to Interpretation of Scores

Subscale I. Case Disposition: Therapy vs. Punishment

A high score on this scale, calculated as Q on the scoring sheet, indicates that the nurse is likely to believe that alcoholics are physically ill and that medical treatment is warranted. A low score is indicative of a belief that alcoholics are in good physical health and should be punished for their alcoholism.

Subscale II. Personal/Professional Satisfaction in Work with Alcoholics

A high score on this scale, calculated as R on the scoring sheet, indicates that the nurse is likely to find work with alcoholics rewarding. She enjoys having them as patients and feels comfortable treating them. A low score indicates feelings of discomfort and embarrassment when dealing with people with drinking problems. Nurses with low scores question their ability to deal successfully with alcoholic people.

Subscale III. Inclination to Identify: Ability to Help Alcoholic Patients

Nurses who score high on this scale, calculated as S on the scoring sheet, tend to see alcoholics as potentially respectable citizens who can be helped to resume normal lives. They are likely to believe that alcoholics want to be cured and that the nurse can help them attain this goal. Nurses who score low tend to believe that alcoholics are selfish and do not want to be helped. The nurse likely believes that if the patient does not try, the nurse should not.

Subscale IV. Perceptions of Personal Characteristics of Alcoholic Persons

Nurses who score high on this scale, calculated as T on the scoring sheet, tend to see alcoholics as basically unhappy people—lonely, sensitive, doubting their own worth, and having severe emotional difficulties. The nurse who scores low on this factor tends to see alcoholics as people who are simply excessive drinkers and who do not have psychological problems.

Subscale V. Personal Attitudes Toward Drinking

High scores on this scale, calculated as U on the scoring sheet, indicate that the nurse probably believes that alcohol per se is not bad. Moderate consumption of alcohol may actually be beneficial. Nurses who score low on this scale probably believe that the danger is in the alcohol and not in the person—the consumption of alcohol in any quantity is harmful, if not morally wrong.

Approximate Norms

All data are based on the original sample of 439 nurses in Buffalo, New York. Approximately 30 percent were community health nurses and 80 percent were hospital based. Statistical tests revealed that hospital-based and community health nurses differed only in their scores on Factor III, Inclination to Identify and Ability to Help Alcoholic Patients. The community health nurses scored higher on this factor indicating that they were more willing to identify and felt better able to help the alcoholic person than did the hospital-based nurses. Norms are therefore based on the entire sample for all factors except Factor III, the norms of which are based on the community health nurse subsample.

Norms are reported as quartile ranges. According to the chart below, one quarter of the nurses in the sample group had the scores indicated in each of the four columns. These norms should be considered only approximate, however, because the questions used on the original 100-item questionnaire and on the present 30-item questionnaire differ slightly in form.

If desired, individual participants may compare their scores against the norms developed from the sample group. For example, if a participant has a score of 27 on Factor I, that means that only 25 percent of the sample group scored higher.

Subscale	N	1st Q	2d Q	3d Q	4th Q
I	436	6-23	24-25	26-27	28-30
II	439	6-17	18-19	20-21	22-30
III	78	6-19	20-22	23-24	25-30
IV	433	6-12	13-14	15-16	17-30
V		*	*	*	*

* Not calculable as original scale contained only three items.

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